Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMND ITM#8&18 PR. INFMT. G798 8-16-01 JAB Certificate of Death 1. Decedant's Neme (First, Middle, Last) 3. Time of Daath 2. Date of Death Month Year **Physician** VONGARLEM 1303P homas 2000 4b. City, Town, or Location of Death 17 /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner BUXNie 7. Age (In yrs. last birthday) If Under A Arundel GEN North Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth 3-25 (Month, Dey, Year) Min. 4. Min. Min. 6. March 5, 1938 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 213 38 1863 1√2 M 2□ F 62 Director Maryland Usual Residenca of Decadent with the Maryland 10c. City, Town or Location 10e. Stete 10b. County 10d. Insida City Limits i and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.

27 is marked other then "natural", or items 23s or 28s-f show that traumatic event, the Medical Examiner man be notified. 1 ☐ Yes 21000 Directo West VA Preston Albright 10e. Street end Number Rt. 1 Box 171 10g. Citizen of Whet Country? 10f. Zip Code 26519 United States Funeral 14. Reca - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces MXYes 2□No If Yes, Give Year or Detes:Vietnam 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Spacify: White 1 Yes 2€ No Specify. þ 3 ☐ Widowed 4 ☑ Divorcad Completed 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada complated) Department of College (1-4or 5+) Elementary/Secondary (0-12) Agriculture 4 12 Director/Management 18. Mothar's Name (First Middle, Maidan Sumama)
MULLIKIN permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: if ftem 27 is marked oth any injury or other traumatic even page. 17. Father's Name (First, Middle, Last) Edward E. Von Garlem Pearl Mulligan 19a. Informent's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Thomas A. Von Garlem Son 1119 General's Highway Crownsville MD 21032 20b. Place of Disposition (Neme of cemetery, crematory or other placa) April 20, Date 2000 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2√Cramation 3 ☐ Removel from State The Metropolitan Crematory Alexandria Virginia 4 Donation 5 Othar (Specify) 21. Signeture of Funeral Servica Licensee 22. Name and Address of Fecility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Entar tha disaasa, or complications thet caused the death. Do not enter the moda of dying, such as cardiac or raspiratory errast, shock, or haert feiture. List only one cause on each line. Approximate Intervel Batween Onset and Death Physician ute CANdiac Hrrhythmia /Medical Immediate Ceuse (Final MINUTES disease or condition rasulting in daath) Examiner Examiner HEART nteriosalerotic Sequentially list conditions, if eny, leading to immediata causa. Entar Underlying Ceuse (Disease or Injury that initiated events rasulting in daath) Last Due to (or es e consequence of) P.O. Box 68760. certificate be Physician/Medical Due to (or as e consequenca of): that the death 23b. Dld tobacco use contribute to the cause of death? Part II, Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 룓 à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, à 書 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed The law r Pass Pass page 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Pleca of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 10 1 ☐ Inpatiant 2 XER/Outpatiant 3 ☐ DOA After this Certification: 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury et Work? 28d. Dascriba how injury occurred 5 Pending invastigation Attending 1 Naturel 2 Accidant 1 ☐ Yas 2 ☐ No death i or Attend after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Phyeician: To the best of my knowledga, deeth occurred at tha tima, data and place, and due to the ceuse(s) end mennar as statad.

2 Privatical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only Deouty 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 00 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) America JONES, MD 2. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene U

Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Dete of Death 3. Tima of Death April 16, 2000 Yaar Physician 2:30 AM Robert Glenn Vencill /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner VA Maryland Health Care System Perry Point Cecil | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day Year) | April 19,1927 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 1 M 2 □ F 72 Vrs 225-34-1937 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location

**Funeral Director** 

28a-f show 238 natural, or

Baltimore, Maryland 21215-0020 1 and 2 should be 1 Health and Mental Item 27 Pages 1 nent of He permit. Pages Department of Important: If It any injury or o once.

KNOWN TO PHYSICIAN: VENCILL, ROBERT

**Physician** /Medical Examiner

The law requires that the death certificate be executed physician and s the burial-trans P.O. Box 68760, Records, Sign Be Division of Vitai or Attending Physician: this death. Director: / To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

Examiner Physician/Medical Completed by Be Medical Certification: To

Director Maryland 10e. Street and Number Funeral 11 Marital Status Be Immediata Cause (Final disease or condition rasulting in deeth)

1X Natural 2 Accident 3 ☐ Suicida 4 Homicide

Neil Cullum

Hospital: 1 Yas 2 No 28a. Data of Injury (Month, Dey Year) 28b. Time of 5 Pending invastigetion 6 Could not be determined

28a. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29b. Signatura end titla of certifiar 29c. Licansa number

Samir Kheiri 30. Nema end addrass of person who complated causa of daath (Itam 23a) (Type, Print)

State Registrar

29a. Cartifiar (Check only one)

32. Registrar's Signatura

9. Birthplace (Steta or Foraign Country) Virginia 10d. Insida City Limits 1 Yes XXNo Churchville Harford 10f. Zip Coda 10g. Citizan of What Country? 3236 Cool Branch Road 21028 U.S.A. 12. Was Decedant Evar in U.S. Armed Forcas? 1 (X) Yas 2 □ No It Yes, Giva Year or Dates: 1945–46 14. Race - American Indien, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3/☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Six Years Collega (1-4or 5+) Maintenance Worker Railroad 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Wilmer Vencill Minnie Lester 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 918 Luke Street, Bel Air, Maryland 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Ø Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata Greenhills Memory Gardens 4/20/00 Richlands, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License NOTHER IN THE LAW IN Perryville, Maryland 21903-0766 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only ona causa on aach lina. Approximate Interval Batween Onset end Death Lung Cancer unknown Dua to (or as a consequence of): Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disease or Injury that initiated events resulting in death) Last Dua to (or es a consequance of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown Hypertension, Atrial Fibrillation 24b. Wera autopsy findings eveilable prior to complation of causa of death? 24a. Was en eutopsy History of Tuberculitis 1 ☐ Yas 2X No 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1X Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

April 16, 2000

Samir Kheiri, M.D., VA Maryland Health Care System, Perry Point, MD 21902

D0052064

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

14503 State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year WEDDING **Physician** CARROLL WILFORD 24 2000 April 8:05 AM \* /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6280 Welcome Rd. Welcome Charles if Under 1 Year If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 1X M 2□ F 82 214-18-8532 March 4, Director 1918 MD Usuel Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits works ! item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Macilial Examiner must be notified at 1 Tes 21 No Directo MD Charles Welcome 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 20693 6280 Welcome Rd. U.S.A. death Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In term 27 is marked other than "natural", or he XXYes 2 No If Yes, Give 6/19/41 Yeer or Dates 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specity: White þ 3 ☐Widowed 4 ☐ Divorced 8/20/45
16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Federal Government Disposal Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Carroll B. Wedding Irene Viola Fones 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5862 Sharptown Rd. Seaford, DE 19973 Mary Jane Moses/Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cem. 4/26/00 Brentwood, Md. 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. MO0995 P.O. Box 567 LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Ischemic Heart Disease disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physician end sthe burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 98 USB signed by the aid be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy Completed completion of cause of deeth? certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 After this funeral 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1. Certifying Phyeicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi Medical

State Registrar

**DHMH 16 Rev 6/95** 

APR 25 2000

30. Name

(Check only one)

29b. Signeture end title of certifier

31. Date filed (Month, Dey, Year)

Ya∕hia M.

llia

M.

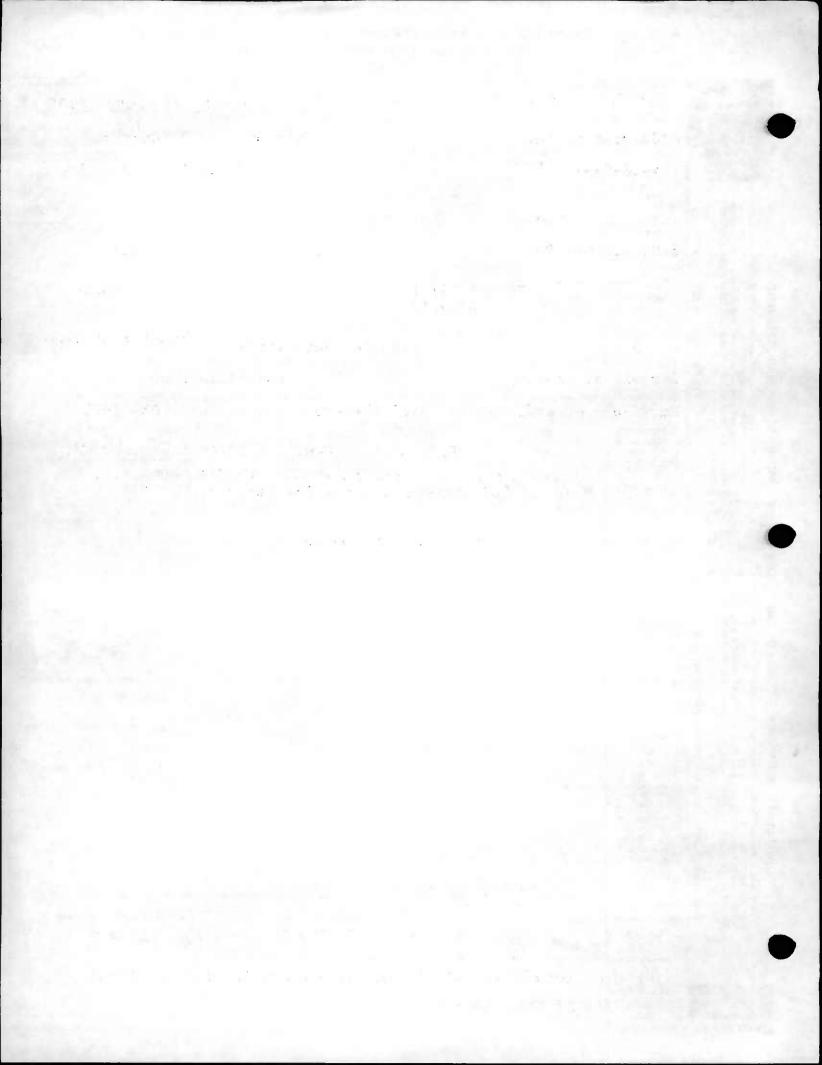
Tagouri, M.D. 32. Registrer's Signeture Deneva

nd eddress of person who completed cause of deeth (Item 23e) (Type, Print)

11655 Wine Sapp Place La Plata, MD 20646

29c. License number D0050883 29d. Date signed (Month, Dey, Year)

24-00



WILLIAMS

MARY

LOTTIE

APR 2 1 7000 James & Species

	Pleas	se Type or State o								II Copies Mental Hy		_egi	ible.	14505	
					Cen	tificate	e of	Death	7		Reg. No.			. 1000	
1. Decedent's Name RUTH	e (First, Middle A. WIL)									2. Dete of De Month April	ath Day		Year	3. Time of Death 8:36 P.M	
4e. Fecility Neme (III	f not institution. CANYON I		mber)							ocation of Death	4c.	County	y of Death	rge's	
5. Social Security N 578-58-53		6. Sex 1 ☐ M 2 ☑ F	7. Age (In ye		hday) (rs.	If Under Months		If Under		8. Dete of Birt (Month, Da	h y, Yeer)		9. Birth	plece (State or Foreigntry)	
Usual Residence of	Decedent									112/1/	13		Masii	· · · · · ·	
Md .						ation o1 H	eig	hts					1	10d. Inside City Limits 1 □XYes 2 □ No	
10e. Street end Nun 7024	mber Canyor	n Drive			10f. Zip Code 10g. Citizen of What 20743						What Coul				
11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		Armed Fo	2X No ve	U,S.		/as Deced Yes, spec				pecify Yes or No- Rican, etc.)			ck, White,	merican Indien, hite, etc. Black	
(0	15. Decedent'	s Education		16e. I	Decede	nt's Usua	I Occu	petion			16b. Kin	d of B	usiness/in	dustry	
Elementary/Secon	ndary (0-12)	t grede completed) College (	1-4or 5+)		(Give kind of work done during most of working life. DO NOT use relired)  Tape Library Assistant U.S. Gor							Gove	rnment		
19e. Informent's Na	M. Ros	SS Ip (Type, Print)		19b.	Meiling	Address	(Stree	18. Moth	er's Nam Saral eer or Rui	ne (First, Middle, h E. Law rel Route Numbe	Meiden S ISON or, City or	Sumer	ne)		
Michael :	S. Will	iams/Hus	band		70	24 C	anyo	on Dr.	.,Caj	p. Hgts.	,Md.	2	20743		
20e. Method of Disp 1 X Buriel 2 ☐ 4 Donation	Cremation	3 □Removal from ecify)	State	Place of cemetery	/, crem	etory or of	ther ple	-	4/26	Dete 5/00			City or To		
21. Signature of Fur	nerel Service L	M. S.	satt			H.S.V	Wash	ess of Fecili ningto rrough	on &	Sons Cove.,N.E.	.,In	c.	D.C.	20019	
23a. Part1. Enter th shock, or hear Immediate Ceuse (F							of dyi	ng, such es	cardiac	or respiretory er	rest,			Approximete Intervel Between Onset end Death	
disease or condition resulting in deeth)	n	eNON	Hodgki	u.s r	ymp	noma		41						20 Years	
		b Barrier	Due to	(or es e co	onsequ	ence of):							1		
Sequentially list con if eny, leading to lmi cause. Enter Under Ceuse (Disease or li	nditions, mediate rlying		Due to	(or es e co	onsequ	ence of):									
thet initieted events resulting in deeth) L		C	Due to	(or es a co	nsequ	ence of):									
Part II Other elonific	cent condition	d.	eeth but not re	esulting In	the unc	terlying ca	in esu	ven in Pert		23h Did t	nhaccou	188 00	ntribute */	the cause of deeth	

**Physician** /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end compilely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit

Division of Vital Records, P.O. Box 68760,

**ledical** Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Heelth and Mantel Hygiene.
Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

2

30. Name end eddress of perso

William

J.

Part II. Other eignificent conditions of Huntington's		sulting In the underlying	cause given In	Pert I.	23b. Did tobacco use con	ntribute to the cause of deeth  3 Probably 4 Unknow
					24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth?
25. Was case referred to medical			26.	Piece of Dea	ath (Check only one)	10,100 20110
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 0	Other		lome 5 Residence 6 □Oth	er (Specify)
27. Manner of Deeth  1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurr	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ HomlcIde determined	28e. Place of Injury - At h building, etc. (Speci	ome, ferm, street, factory)	ory, office		28f. Location (Street end Numb City or Town, State)	er or Rurel Route Number,
29a. Certifier (Check only one) 1 ☑ Certifying Phy	ysician: To the best of my kno niner: On the basis of exemina end manner steted.	owledge, deeth occurre	d et the time, de	te end plece , death occu	, end due to the ceuse(s) end me rred et the time, date end place, e	enner es steted. end due to the ceuse(s)

State Registrar

Cullen.M.D. 1011 N s Signeture Capitol St., N.E., Wash., D.C. 20002 32. Registrer's Sig

NO

npleted cause of deeth (Item 23a) (Type, Print)

29c. License number

22164

DC

29d. Date signed (Month, Dey, Yeer)

April 20,2000

Sant.

CHETE ASA

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month 4 **Physician** 05 **JESSE** WITHERSPOON, JR. 2000 4:15 PM -/Medicar 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva straat and number) **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 16,1916 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) **Funeral** Days 83 579-05-5742 Yrs **Director** Usual Residence of Decedent the Meryland Colomit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mental Hygiena.
Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Upper Marlboro Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9415 Castle Drive 20772 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Detes: 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Raltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by **Black** 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Supervisor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Witherspoon, Sr. Rosa Lee Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Yvonne Cole/Daughter 9415 Castle Drive, Upper Marlboro, Maryland 20772 20b. Placa of Disposition (Name of cemetery, crematory or other place) Park 04/14 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Maryland National Mem. 4 ☐ Donation 5 ☐ Other (Spacify) 2000 Laurel, Maryland 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 ·en 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CARDIAC Examiner Due to (or as a consequenca of) Physician/Medical Examiner Sepsis syndu attanding physiclan end for use as the bunel-trensit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequenca of) Division of Vital Records, P.O. Box 68760, INTect that Initiated events resulting in death) Last Dua to (or as a consequenca of): eretet signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MVA þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Advance 2 No is certificeta I 1 Yes 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation Natural death. To the Hoapital or Attendit within 24 hours after death.
To the Funeral Director; Al completaly filled in by tha fu 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide S Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as steled.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certile 1)0052865 2000 ion who completed cause of death (Item 23a) (Type, Print) 30. Name and add Michael Figaro, M.D., 3001 Hospital Drive, Cheverly, Maryland 20785 32. Registrar's Signature 31. Date filed Month, Day, Year) APR 2 0 2000 Registrar

THE ENGINEERING PARTY OF PRESENTING AND THE PROPERTY OF

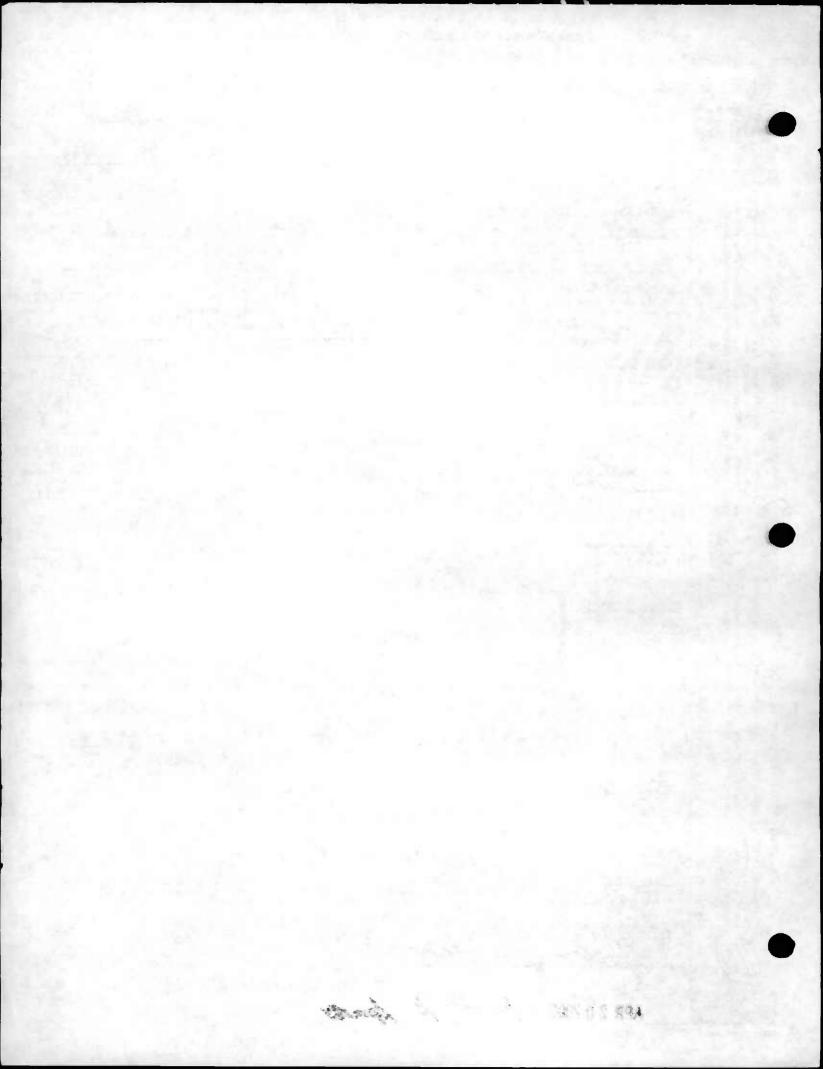
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State of Maryland / Department of Health and Mental Hygiene 11,507

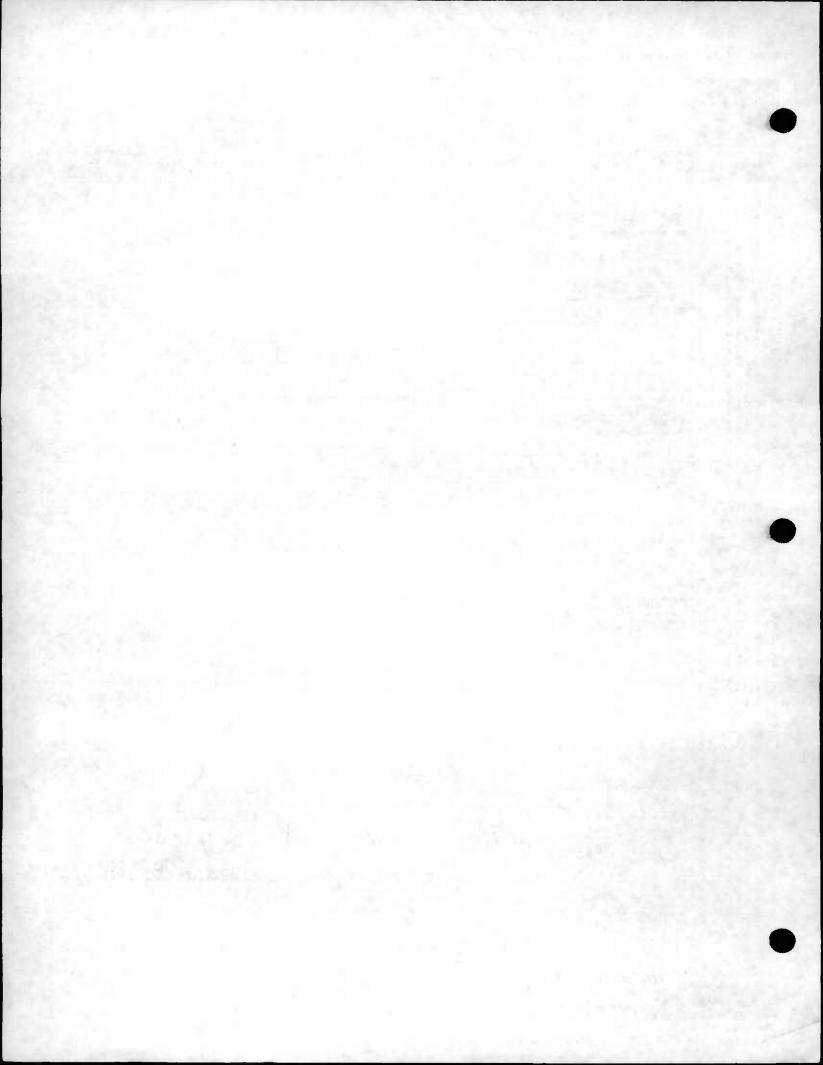
y L. Walke.	2		Certificate of I	Death	R	leg. No.	3 1 1	1307
Physician	1. Decedent's Name (First, Middle, Las		18-11-27		2. Date of Dee Month	Dey	Yeer	3. Time of Deeth
/Medical	HENRY LEWIS	WALKER, JR.				15, 200		1:45 A.M.
Examiner	4a Facility Neme (If not institution, give		4	tb. City, Town, or Lo		4c. County		
	5513 59th Avenu 5. Sociel Security Number 6. §		t hirthdey) If Under 1 Year	Riverda  If Under 24 Hrs.			e Geor	ge's e (Stete or Foreign
Funeral Director		OM 2□F 51	Yrs. Months Deys	Hours Min.	8. Dete of Birth (Month, Dev JULY 2	4, 1948	VTRG	INIA
a-f ehow	10a. Stete 10b. County MARY LAND PRINCE	GEORGES 10c. City,	Town or Location RIVERDALE					Inside City Limits X⊠Yes 2□No
ath with the Maryler 23a or 28a-1 ehow wat be notified at ral Director	10e. Street and Number 5513 59TH AV	ENUE	10f. Zip Code 20737			10g. Citizen of Whet Country? UNITED STATES		
her der	11. Maritel Stetus  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X X X No If Yes, Give Yeer or Detes:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	ecify Yes or No- Rican, etc.)	s or No- tc.)  14. Race - American Indien, Black, White, etc.  SpecifAFRO - AMERI(			
Maryland 21215-0020 Id 2 should be filed within 72 hours aff the and Mantal Hygiene. It's marked other than "natural", or traumatic event, fre Medical Exam To Be Completed by F	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decadent's Usuel Occup (Give kind of work done of life. DO NOT use retired AUTO BODY	etion du <i>ring m</i> ost of works d) WORKER	ing	PRIVATE		
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Wental Mental Me	HENRY LEWIS	WALKER, SR.		WALKER				
	19e. Informent's Neme/Relationship (1 LINDA WALKER,		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 5513 59TH AVE., RIVERDALE, MARYLAND 2					
nore;	20e. Method of Disposition  1 X8virial 2 Cremetion 3	Remove State OAK	ce of Disposition (Name of Disposition (Name of Disposition) or other please UNION BAP. CH.		Data	20c. Location -		SVILLE, V
Callimore, commit. Peges 1 e Cepariment of Hee Important: If Nem any Injury or othe once.	4 Donetion 5 Other (Specify 21. Signature of Fundral Service Lices	my Holler	22 Name and Addre	ss of Fecility NERAL HOMI	=			
	234 Partt. Enter the disease, or com	EDWARD M. DUDLE						D 20712
death certificate be executed the strength of the set o	Immediate Ceuse (Finel disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or e	as a consequence of):				1 1 1 1 1 1 1	
M See	resulting in deeth) Lest	d	s e consequence of):					
bet the detached by the Phys	Pert II. Other significant conditions of Chronic Alcohol		ing in the underlying cause giv		Did tobacco use contributa to the cause of dea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkn			
aw requi					24a. Wes a	an autopsy med?	eveila	autopsy findings able prior to eletion of cause ath?
The I					1 <b>∑</b> Y	'es 2□No	1 🖔 Y	res 2□ No
ician: The contilicate medior, pe	25. Wes case referred to medical examiner?		lou	26. Plece of Deet	h (Check only o	ne)		
Physician: this cartific ral director.	1 X Yes 2 No		R/Outpetient 3 DOA	4 LI Nursing Ho			-	
all or Attending P is after death.  It Director: Ahari ed in by the funeric Certification:	27. Menner of Death 1 Maturel 5 Pending 2 Accident investigation	(Month, Dey Year)	8b. Time of Injury M 28c. Injur	y et fk? Yes 2 □ No	28d. Describe h			
a alter d a libract ad in by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (S City or Tow	Street end Numb vn, State)	ber or Rural R	loute Number,
Hospi 24 hou Funer tely till		ysician: To the best of my knowled niner: On the bests of examination and manner steted.						
To the within 1 of the pomple	29b. Signeture and title of certifier	I Chute in	W	O.C.M.E.		29d. Date signe April 1		
(10)	30. Name end eddress of person who Dennis Chute M.		3e) (Type, Print) 111 Penn Str	eet, Balt	imore,	Marylan	d 2120	)1
State Registrar	31. Dete filed (Month, Dey, Year)  APR 2 0 2000	Registrer's Signetur	3. ponts					



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State of Maryland / Department of Health and Mental Hygiene 00 14508

				Ce	rtificate	e of	Death			Reg. No.		
Dhusisian	1. Decedent's Name (First, Mide	The second second							2. Dete of De Month	eth Day	Year	3. Time of Daath
Physician /Medical	Tanun Wic	hainaraph	ong	(6)					April	21, 200		1051 am
Examiner	4a Fecility Name (If not instituti		ım <i>ber)</i>				4b. City, To	own, or Lo	ocation of Deeth	4c. Count	y of Deeth	
	Johns Hopkins	_			T WILL AS	4 2	Balt		_	N/A		
Funeral	5. Sociel Security Number 212-51-1465	6. Sex 1000M 2□ F	7. Age (In yrs.	<i>last birthday)</i> 13 Yrs.	If Under Months	Deys		Min.	8. Dete of Bird (Month, De April 7	y, Year) 1987	9. Birth	plece (Stete or Foreig htp) LLLand
irector		Jsuel Residence of Decedant										
* w	10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limit
natural, or term 23s or 28s-1 show dies Examiner ment be notified at etcd by Funeral Director	Maryland How	ard		Ellico	tt Ci	tv						1 ☐ Yes 2 🖾 N
Director	10e. Street and Number				10f. Zip					10g. Citizen of	What Cou	ntry?
	10274 Glob	e Drive				210	42			Tha	iland	1
Funeral	11. Maritel Status		cedent Ever in U	,S. 13.	Was Deced	dent of	Hispenic Or	igin? (Sp	ecify Yes or No Rican, etc.)		ce - Ameri	can Indian,
F	1√2 Never Married 2 ☐ Me	rried 1 ☐ Yes If Yes. G	2√2 No		1 ☐ Yas	-			, , , , , ,	Speci	6	
d by	3 Widowed 4 Divorce	d Yeer or I	Detes:								ASI	
lete	15. Deceda (Specify only high	nt's Education as <i>t grade completed)</i>	de completed) (G.			Decedent's Usuel Occupation Give kind of work done during most of working life. DO NOT use retired)				ing 16b. Kind of Br		dustry
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	21. Signatura of Funeral Service			2	2. Name an	d Addr	ess of Fecili	ity	2000			
		VI							Family			
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as the bunar-transit	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying											1 1 12
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by P			21-70							100 20110	•	<b>/</b>
Completed t										a. Was an autopsy performed?		Vere autopsy findings veilable prior to empletion of cause daeth?
E									100	Yes 2□No	1	Xyes 2□ No
BeC	25. Was case referred to medic	al					26. Plac	a of Dee	th (Chack only	one)		
To B	examiner? 1XXYes 2□ No	Hospitel: 112	Inpatient 2	ER/Outpatie	nt 3 DC	DA O	ther:		ome 5□Resi	O-01	her (Spec	(fv)
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5	3 Suicide 6 Could 4 ØNdomicide deter	mined 288. PIEC	e of Injury - At h	oma, ferm, st	reet, factory	y, office	N.		281. Location (	Street and Num	ber or Ru	rel Route Number,
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edical		ing Physician: To the i Examiner: On the band man										stated to the causa(s)
Medical Cert	29b. Signature and title of cartif	er	_		290	c. Licer	se number			29d. Date sign	ed (Month	, Day, Year)
	1-160	. 11. V	1	Lea A	5	o.c	.M.E			April	22, 2	000
	30. Name and address of perso	n who completed cau		n 23a) (Type	, Print)				1	-		
	THEORORE 1	liking/		1	11 Pe	nn	Stree	t, B	altimor	e, Mary	land	21201
State	31. Dete filed (Month, Dey, Yea	32.1	Registrer's Signe									
gistrar	APR 2 4 200	10 Sens	me ,	9. 4	DOLK	21						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Year **Physician** May 2, 2000 8:56 am Margaret M. Atwell /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3502 Sharonwood Road APt. 2E Laurel Anne Arundel 5. Social Security Number if Under 1 Yaar | if Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Jan. 29, 1917 Birthplece (State or Foreign Country) Funeral 1□M 200 F Months Deys Hours Yrs. 218-03-9797 83 Director Maryland Usual Residence of Decedent 10a. Stete - would 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XX Director Md 284-1 Anne Arundel Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò natural', or items 23a 3502 Sharonwood Road Apt. 2E U.S.A. 20724 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ Xo 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2/2t/No Specify Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementery/Secondary (0-12) College (1-4or 5+) filed with Hyglene. 12 Ø Secretary other t Legal pemit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event 17. Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Herbert A. Moffat Annie Spicer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Eugene A. Atwell Husband 3502 Sharonwood Road Apt. 2E Laurel, Maryland 20724 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) †☐Burial 2 ☐ Cremetion 3 ☐ Removal from State Meadowridge Memorial Park 5-5-00 4 ☐ Donetion 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral 22. Name and Address of Fecility Fleck Funeral Home Inc. 7601 Sandy Spring Road Laurel, Maryland 20707

Approximate

Approximate 23a. Part1, Egft shock, or Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final diseasa or condition resulting in deeth) /Medical day Examiner Physician/Medical Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): Records, P.O. Box 68760. attending physician for use as the bune thet initiated events resulting in deeth) Lest Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Denknown ģ 24b. Were eutopsy findings available prior to complation of causa of deeth? Completed 24a. Wes en eutopsy 1 ☐ Yas 2 ☐ No 1 Yas 2000 certificata Division of Vital or Attending Physician: Be 25. Wes casa referred to medical examiner? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menneyof Deeth 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Neturel To the Hospital or Attendit within 24 hours after death.
To the Funerel Director: All completely filled in by the fu 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner steted. 29a. Certifier 29b. Signeture end title of certifip 29c. License number 29d. Date signed (Month, Dey, Year) 00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) sowie 14333 daurel 31. Date filed (Month, Dey, Year) 32. Registrer's signetura State Registrar

**DHMH 16 Rev 6/95** 

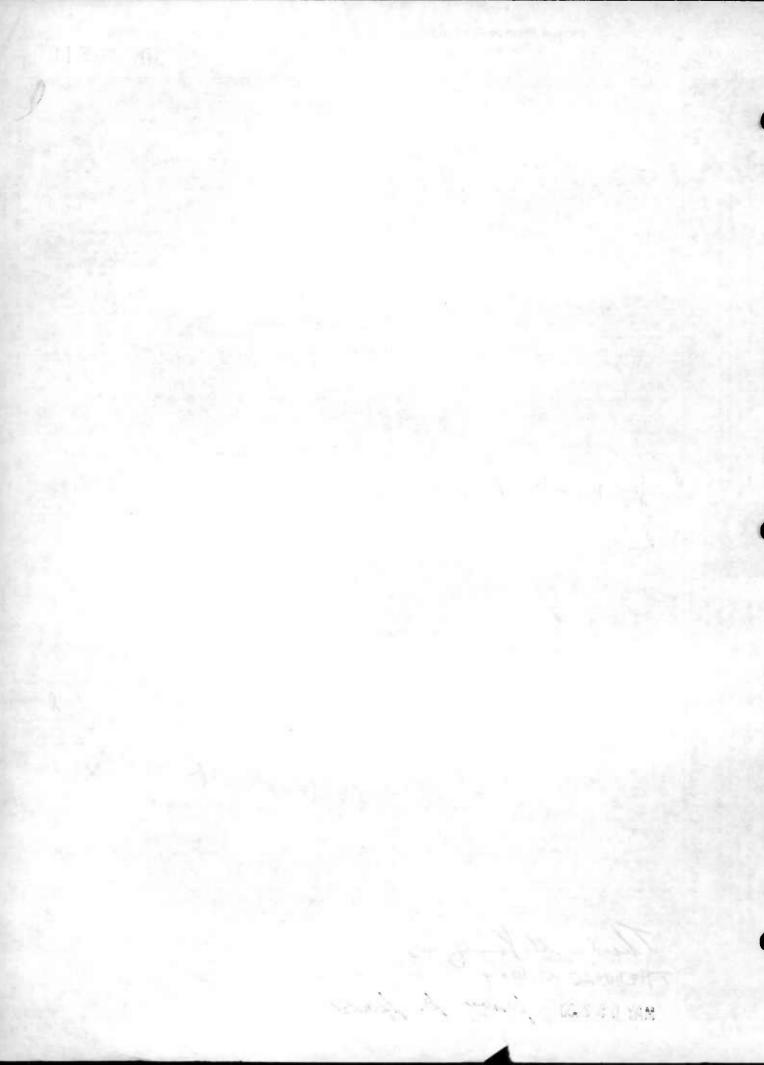
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| Long Green Nursing Home N/A 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Euneral** 1 M XXF Yrs 84 Director 128-24-8256 Poland Usual Residence of Decedent the Maryland r 28a-f ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits X⊠Yes 2□No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 5 Department of Health and Mental Hyglena. Important: If Itam 27 is marked other than "natural", or items 23a or 2 and 2 house. 3631 Ash Street 21211 USA Completed by Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ≫ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Race · Amaricen Indian. Black, Whita, atc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2€No Specify: Specify: ¾⊠ Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Actress Theater Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) Be Carl Anastasia 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanora Aldersen Baltimore, Maryland 2121 Daughter 3631 Ash Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from Stata Baltimore National 5/1/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service License 22. Nama and Addrass of Facility 3631 Falls Road Baltimore, Maryland 2121 Den SOST FAITS ROAD BATCINO

To complications that crused the death. Do not entar the moda of dying, such as cerdiac or raspiratory arrest, lat only one cause on shirth line. Approximata Intarval Between Onsat and Death 23a. Part T. Enter the dis shock, or heart fail **Physician** /Medical Immediata Causa (Finel diseasa or condition resulting in death) weeks Examiner Dua to (or as e conseque Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury Pug Records, P.O. Box 68760, cass ialets 10 that initiated events resulting in death) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown ۵ page 2 should be Be Completed 24b. Ware eutopsy findings available prior to 24a. Was an autopsy completion of ceuse of death? 1 Tas 1 ☐ Yas 2 ☐ No cartificate of Vital funaral director, 25. Was cesa refarred to medical examiner? 26. Place of Death (Check only one) Other: Medical Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Homa 5 Rasidance 6 Othar (Specify) this 27. Manner of Death 26a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division Affer To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 Metural 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Secritifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and mannar as stated.

\*\*To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and mannar as stated.

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\*\*To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and mannar as stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) Hendrai 4,2000 017118 30. Name and address of parson who completed causa of death (Item 23a) (Type, Print) up 1(5E 32. Registrar's Signatura State Registrar **DHMH 16 Rev 6/95** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May 3 2000 Albert E. Anderson 9:15 am 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 824 Selby Blvd. Anne Arundel Edgewater If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Aug. 2, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 1 M 2□ F Months Hours 578-22-6330 75 Aug. Washington, DC Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. toside City Limits 1 ☐ Yes 2 No Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 Selby Blvd. 21037 USA 12. Was Decedant Evar in U,S. Armed Forces? VOXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, White, etc. 1 Never Married XXMarried 1 ☐ Yas 2XXNo Specify: If Yes, Giva Year or Datas: WWII White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Local 100 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Albert E. Anderson Clara Penkert 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia K. Anderson (Wife) 824 Selby Blvd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Neme of 05/04 20c Location - City or Town, State cemetery, cremetory or other piece) MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 2000 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sticemes 3 week Due to (or as a consequence of) Bureak Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ( Due to (or as e consequence of): Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an eutopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

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**Funeral** 

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permit. Pages 1 end 2 should be filed within 72 hours effer to Department of Heelth end Mentel Hygiena. Important: if fem 27 is marked other than "natural", or fee eny injury or other traumatic event.

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the attending physician end the for use as the bunal-transit The law requires that the death certificate be executed Box 68760, P.0. à Records, page certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Certification:

DHMH 16 Rev 6/95

Registrar

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31. Dete filed (Month, Dey, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1□Yes 25No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicet 26. Place of Death (Check only one) 1 Yes 25 No Hospitet: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner steled. edical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

d ceuse of death (Item 23a) Hype, Printi

MAY 0 5 2000 James & Apreción

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14513 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year Physician APRIL 29, WILLETTE E. BYRD 2000 1:00pm /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner 1831 W. BALTIMORE ST. BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number **Funeral** Days 1 M 2 XF 76 217-22-5374 Yrs Director N.C. 2-19-1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. State 10b. County pemit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Heelth end Mantal Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at 1 ∑Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 1831 W. BALTIMORE ST. USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be LUCILLE HARRIS JOHN YOUNG 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) BARBARA E. YOUNG (DAUGHTER) 31 UPMANOR RD. BALTIMORE, MARYLAND 21229 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date -5-2000 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removel from State BALTIMORE, MARYLAND 4 ☐ Donetion \_ 5 ☐ Other (Specify) BALTIMORE NATIONAL CEMETERY 21. Signeture Funeral Service License 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. rec 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ona than Approximate Interval Between Onset end Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final MASSIVE STROKE disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CEREBRO VASCUL AR ARTERIO SCLEROSIS ed by the attanding physician end detached for use as the bunal-transit law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detached 1 Yea 2 No 3 Probably 4 Unknown HYPER TENSION þ 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy Completed performed? hes 1 Yes 2 18 No 1 ☐ Yes 2 ☐ No cartificata funeral director, 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 10 1 Yes 2 No this 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After 1 W Natural 5 Pending after deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours after Funeral Dire letaly filled in b 6 Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated. Medical pletaly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the P 29d. Date signed (Month, Day, Year) 29b/Signature and title of certifier 29c. License number Tebbar MD

SUITE 39 BALTIMORE MD 21201

State Registrar 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

JOHN B. MACGIBBOND 300 ARMORY PLACE

MAY 0 5 2000

31. Date filed (Month, Day, Year)

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MAY DE SEN

The law requires that the death certificeta be executed Box 68760. P.O. Records, of Vital al or Attending Physician: The state deeth.

In Director: After this certificeted in by the funeral director, pa Division

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

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**Physician** /Medical

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page 2 should

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Physician/Medical Examiner

Be Completed

Certification: To

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filed within 72 hours after

Baltimore, Maryland 21215-0020

To the Hosp within 24 hor To the Fune completely fi Registrar

State

31. Date tiled (Month, Dey, Year)

29b. Signature and title of certifier

MAY 0 5 2000



30. Name and eddress of perhan and completed cause of death (Item 23a) (Type, Print) Graham

29c. License number

20314

Redgrave,

29d. Date signed (Month, Day, Year)

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AN THINK

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ () Amended Item#28a-f perPhyG785 7/25/2000 EW Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 1510 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Broadmead Cockeysville
If Under 24 Hrs. 8. Dete Baltimore 8. Dete of Birth (Month, Dey, Year) If I Inder 1 Year Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 5 Months Min. Deys Hours Yrs 003-18-4949 Director 99 Jan. 27 1901 MA Usual Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any lujury or other traumatic event, its Medical Examinat must be notified at each. 10a Stete 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 XNo MD Baltimore Cockeysville Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code JSA 14. Rece - American Indien, 13801 York Rd Funeral 21030 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck. White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Librarian-Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Astor Aitken Harriet Varley ည 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Russell Varley/cousin 1247 Somerset Ave., Dighton, MA 02715 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e Method of Disposition 1 ☐ Buriel X Cremetion 3 ☐ Removal from State 4 Denation 5 Other (Spin Baltimore Wash. Crematory 5/4/00 Laurel, MD 22. Name and Address of Facility Lemmon Funeral Home Man Bryan W. Clary 10 W. Padonia Rd., Timonium, MD 21093 caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, each line. Approximete tntervel Between Onset end Death 23a. Pert1. Enter the diseese, or complice shock, or heart feilure. List only one **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last pue Due to (or es e consequence of): buniel-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the burie Physician/Medical the Due to (or es e consequence of): isigned by the a 23b. Did tobscco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy peen performed? page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No certificete After this certifice funeral director, or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Injury 1 Natural 5 Pending efter death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4;15 Subject injested multiple medications investigation 5/1/2000 6 Could not be determined 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 Homicide Brookmead Cockeysville, Md. 24 hours e Nursing Home -Brookmead Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier 29c. License number 2000 use of deeth (Item 23e) (Type, Print) /// Ha 31. Dete filed (Mo 32. Registrar's Signature

DHMH 16 Rev 6/95

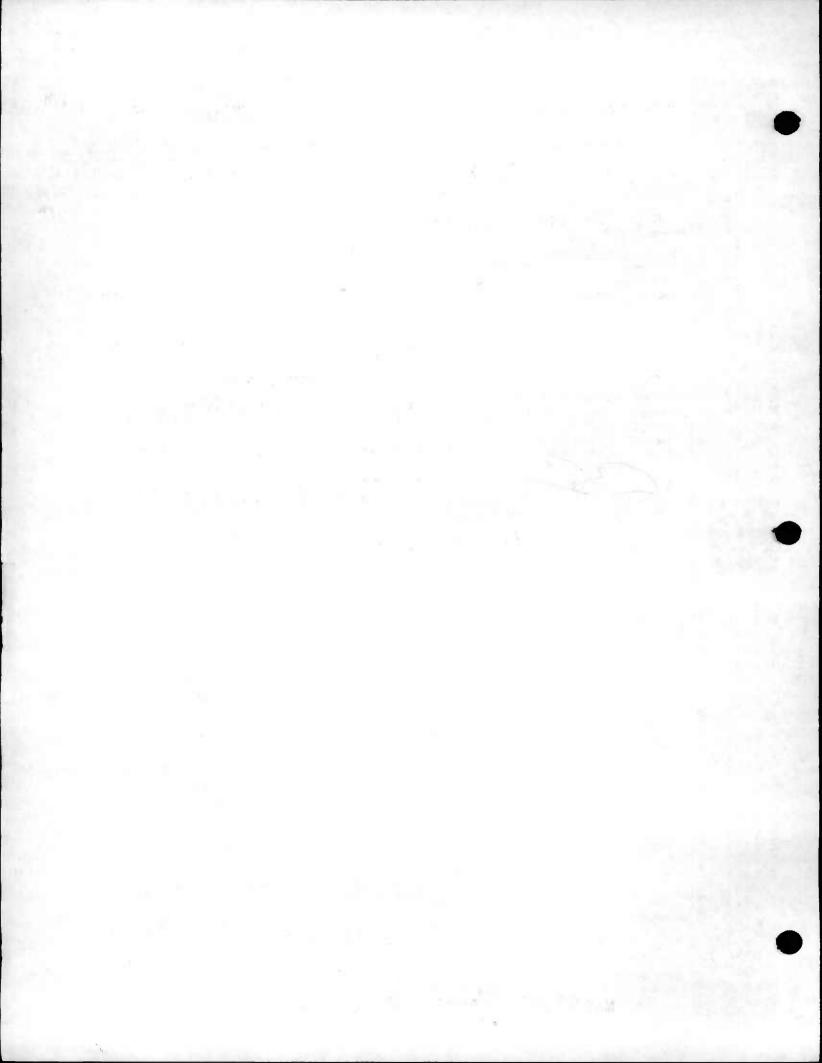
State Registrar

MANY STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene 4516

			State of	iviai yiai k			of Death	iu ivieritai n	Reg. No.		
Physicia /Medica		1. Decedent's Name (First, Middle, Juliana B. Broo						2. Date of D Month May	Day	Year	3. Time of Death
Examine		4a. Facility Name (If not institution,	give street end numb	per)			4b. City, Town	n, or Location of Dea		y of Death	
Funeral Director		2000 Wilhelm A	enue 6. Sex 7. 1□ M 2M F	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Y Months Da		Hrs. 8. Date of E Min. (Month, I	lirth De <i>y, Year)</i>	imore 9. Birthpl Coun	lace (Stete or Foreign try)
pu *		Usual Residence of Decedent  10a. State 10b. County			, Town or Lo	cation		- June - J	<del>,</del>		0d. Inside City Limits
th with the Marylar 23a or 28a-f show	5	, , , , , , , , , , , , , , , , , , , ,				341011				, ,	1 Yes 2 No
h the	20	MD Baltimo	ore	Kose	edale	10f. Zip Cod	de		10g. Citizen of	What Coun	try?
th wit	<u>a</u>	2000 Wilhelm A	zenije			212	237		MD		
d 21215-0020 filed within 72 hours efter death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f show out, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	12. Was Decede	es? MaNo			of Hispanic Origin Cuban, Mexican, I No Specify:	n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Ra Bla Specii	ce - America ck, White, e	
15-00%	ted	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Usual Oc	ccupation	of working	16b. Kind of B	lusiness/Ind	lustry
Maryland 21215-0020 to 2 should be filed within 72 hours ef tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)			one during most o stired)	ii workiiig			
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C Salo	o Be	Peter Balko	251)					(Unknown)	e, maideri Surriai	ne)	
re, Maryland 2 s 1 and 2 should be filed Health and Mental Hypi tem 27 is marked other other traumatic event, in	٥	19e. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (St		`	ber, City or Town	, State, Zip	Code)
		Frederick Brooks	s/Son		200	ALti	more	or Rural Route Num	3133	7	
Baltimore, emit. Peges 1 ar bepertment of Hea mportant: if item 2 my Injury or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation	P C Romoval from St	0.0	ace of Dispo	sition (Neme onetory or other	f	Date	20c. Locetion		wn, State
Peg ment ant: I		4 Donation 5 Other (Sp		Gard	dens o	f Faith	ı	5/5/00	Baltimo	re, M	D
Baltimore, pemit. Peges 1a Depertment of Hee Important: if item any Injury or othe once.		21. Signature of Funeral Service L				Cvach/F	ddress of Facility Rosedale	Funeral	Home	227	
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cau	sed the death	. Do not ent	er the mode of	lesaco Andying, such as ca	ve. Balto ardiac or respiretory	arrest,	237	Approximete Interval Between
Physician /Medical Examiner	ner	Immediate Ceuse (Final disease or condition resulting in death)	e. MY	OCAR	MA	2/	N FAY	SCHON	/	)113G	Onset and Death
58760, icete be executed physician end s the buriel-trensit	a Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	6.		as a conseq	, ,					
ox 68760, or certificate be exampled by some or the buriel.	n/Medical	that initiated events resulting in death) Last	d	Due to (or	as a conseq	uence of):					
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Division To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	edical Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	Injury - At hor , etc. (Specify)	me, farm, str	eet, factory, off		28f. Location	(Street end Num own, Stete)	ber or Rurei	l Route Number,
DIVI	dical	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the be caminer: On the basi end manner	s of examinetic	ledge, death on and/or inv	occurred at th	e time, date and p ny opinion, deeth	place, and due to th occurred at the time	e cause(s) and m e, date and place,	anner as sta	ated. the cause(s)
vithir To th	-	29b. Signature and title of certifier	1		4	29c. Lic	ense number		29d. Date signe	ed (Month, L	Day, Yeer)
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00		30. Name and address of person w	2 261	5.10	41618	Print) ADD	AVE,	BOTT.	47	21	224
State Registra	-	31. Date filed (Month, Day, Year)  MAY 0	5 2000 32. Reg	Israr's Signatu	ure &	do	alis				,

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 2, 2000 **Physician** Wesley E. Carter 8:00 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3843 Beatty Road Harford Monkton If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months FEB 14, 133-30-7155 62 1938 Director Kentucky Usuel Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natures" any injury or other treumatic exercises. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes X ☐ No Director Harford Monkton 10a, Street end Number 10f. Zip Coda 10g, Citizen of Whet Country? 3843 Beatty Road 21111 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Electrical Engineer Designer 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Wesley E. Carter Lucille Myers 2 19a. Informent'e Neme/Reletionship (Type, Print) Ann Carter/Sister 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Box 1868 Pagosa Springs, CO 81147 P.O. 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5/3/00 Metro Crematory, Inc. Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funetal Servica Licensee Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD Approximete Interval Between Onset end Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Physician Immediata Ceusa (Final disaasa or condition resulting in death) /Medical duodenum Carcinoma enmontes Examiner Due to (or es a consequenca of): attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediala cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequenca of): 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ been si Completed 24a. Wes en eutopsy parformad? 24b. Were eutopsy findings available prior to completion of cause of death? has 1 Tyes 2 DNo 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Aasidenca 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menne of Deeth 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner steled. edical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Nema and address of person who complated cause of death (Item 23a) (Type, Print) North Charles owson, 31. Dete filed (Month, Day, Year) 82. Registrar's Signatur State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene | 1 | 5 | 8

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4a Facility Nama (If not instituti				cation of Death	4c. County of I	Jeath	
5013 Colum 5. Social Security Numbar	bia Rd. Apt.	#203 ge (In yrs. last bi	nthday) If Under 1 Year	Columbia  If Under 24 Hrs.	9 Date of Birth	Howar	d. Bishelma (State as Familia
212-52-4826	1□M 2EF	97	Yrs. Months Days		8. Data of Birth Month, Day, March 1	8,1903	Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedant  10a. State 10b. Coun	ity	10c. City, Tow	m or Location				10d. Inside City Limits
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10e. Street and Number	wald	1 001	10f. Zip Code		10	g. Citizen of Wha	t Country?
5	7			0.4.4			
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1 □ Nevar Merriad 2 □ Ma 3 ☑ Widowed 4 □ Divorce	Armed Forces? arried 1 ☐ Yas 2 ☑ If Yas Giva		13. Was Decedent of if Yes, specify Cut  1 ☐ Yes 2 No		Rican, etc.)		White
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19a. Informant's Name/Relation	nship (Type, Print)	198	o. Meiling Address (Stree	t and Number or Run	al Routa Number,	City or Town, Ste	ite, Zip Code)
Jacquelyn Lingg	/Daughter	8	3425 Glenmar	Road Ell:	icott Cit	tv. MD 2	1043
20a. Mathod of Disposition		20b. Place o	of Disposition (Name of ory, cremetory or other pla	ace)		0c. Location - Cit	
1 ABurial 2 Cremetion 4 Donation 5 Other	n 3 □Removal from Stata (Soecify)				6 2000	Deltimo	an MD
21. Signature of Funeral Sarvice		no1044	ine Park Ce	ass of Facility	-6-2000	Baltimo	re, MD
1 San 1	1.00	000	Harry H.	ass of Facility Witzke's I	Family Fr	neral H	ome, Inc.
Son Both State State	Occus or	ezee	4112 Old	Columbia I	Pike Ell:	icott Ci	ty, MD 21043
23a. Part1. Enter tha disaasa, shock, or heart failura. Li	st only one cause on each li	ine.	not enter the mode of dy	ing, such as cardiac	or respiretory arre	St,	Approximata Intarval Between Onset and Death
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 14519

	Certificate of Death	,	Reg. No.	4319
ysician	1. Decedent's Name (First, Middle, Last)	2. Dete of De		3. Time of Death
nysician Medical	Mary Elizabeth Cottrell	May 4	, 2800 Year	6:50 AM
caminer	Good Samaritan Nursing Home Baltin		N/A	
eral ector	5. Social Security Number  215-03-6803  Contact Security Number  1	Min. (Month, Da		rthplace (State or Foreign country) ryland
all l	10a. Stete 10b. County 10c. City, Town or Location			10d. toside City Limits
rector	MD Baltimore Fullerton			1 ☐ Yes 213 No
Funeral Director	10e. Street and Number 10f. Zip Code 21206		10g. Citizen of Whet C	•
by	11. Marital Status  12. Wes Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Wes Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Am Bleck, Wh Specify: W	ite, etc.
eted	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most or	f working	16b. Kind of Business	/Industry
Completed	Elementary/Secondery (0-12) 12 College (1-4or 5+) Payroll Supervisor		Manufact	uring Co.
		Neme (First, Middle		uring co.
To Be		orie Campb		
	19a. Informent's Name/Relationship (Type, Print)  David Gerstmyer  19b. Meiling Address (Street end Number of 4626 Greenhill Aven			
	20a. Method of Disposition  1	Dete 5/6/00	20c. Location - City o	Town, Stete
	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility	John C. M	Miller Inc.	
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caused the death. Do not enter the mode of dying, such as caused the death.			Approximete interval Between
	Immediate Cause (Final disease or condition resulting In deeth)  e			Onset and Death  ZIMCS  /month
iner	1 Sy Dova on 10			/ month
edicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ocause, (Disease or injury C.			6mos
5	thet initieted events resulting in death) Lest  Due to (or as a consequence of):			
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edicai C	29a. Certifier (Check only one)  1 McCertifying Physician: To the best of my knowledge, deeth occurred at the time, date end proper stated and proper stated.	place, end due to the occurred et the time,	cause(s) end menner a	as steted. se to the cause(s)
Medical Certification:	29c. License number		29d. Date signed (Mor	oth, Day, Year)
	1 Mula Alder 1 un Mar	390	5/4	1200
	30. Name end address of person who completed cause of death (Item 23e) (Type, Print)	- / -	0.01	
	CHARLES F. HOESCH GOOD SAMARTIN	AN MURS	ENG	
State	31. Dete filed (Month, Dey, Year)  32. Registrar's Signeture			
istrar	MAY OF 2000 house of south			

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

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uneral irector		5. Sociel Security Number 216-16-1879 Usuel Residence of Decedent	6. Sex 14∑ M	/ 2□ F	7. Aga (In yrs.	last birthday) 7 5 Yrs.	If Under 1 Ye   Months   De		er 24 Hrs. Min.	8. Dete of Birt Month, De 9-18-	1 924	9. Birth	place (State or Foreigntry) MD.
d.m.	_	10a. Stata 10b. Cour	nty		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limit
all	Director	MD. N/	A		I	BALTIMO							1₽ Yes 2□N
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or oth		20e. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3∏Rem	novel from S		Plece of Disponentery, crea	osition (Neme of metory or other	oleca)		Dete	20c. Location		
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nyland	3	10a. State 10b. Coun			Town or Lo					1	Inside City Limits
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21215-0020 d within 72 hours af giena. rr than "natural", or	r, the Medical	Elementery/Secondery (0-12)	-	(1-4or 5+)	life. E	00 NOT use retire 1 Clerk	d)		11 S P	nstal S	Service
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	completely filled in by the funeral dire Medical Certification: To	27. Menner of Death  1. Natural 5 Penc 2 Accident inves 3 Suicide 6 Coul	28e. De (M	te of Injury onth, Day Year)	R/Outpatien 28b. Time of Injury	28c. Inju Wo	4 Li Nuising no	28d. Describe	idenca 6 □Oth how injury occur	red	
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December   Control   Con			Certificate of Death	Reg. No.	
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The control of the		4a Facility Name (If not institution, give street and number)	4b. City, Town, or		
The control of the	<u> 18</u>	JOHNS HUDKING BOUNEW ME	dient Center BRITIN	nape Cit	VA
The content of the	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24 Hrs	S. 8. Data of Birth	9. Birthplaca (Stata or Foreign
Use State of December of December   100 College   100 Co		213-03-1748 10M 200 86	Yrs. Months Days Hours Mill	ADRIL 28-1914	
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Section   Continued   Contin	or 2	10e. Street and Number	10f. Zīp Code	10g. Citizen of W	hat Country?
Section   Continued   Contin	\$ 23 E	230 N. LUZERNE AV.	21224	Us	SA
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Physician Physic	P. P. B. B.				
Section   Continued   Contin	d b	3 2 Widowed 4 Divorced Year or Dates:		Openly.	WHITE
Physician Physic	72 t 72 t	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b. Kind of Bus	siness/Industry
Section   Continued   Contin	ithin and and and and and and and and and an	Elementery/Secondary (0-12) College (1-4or 5+)			
CHARLES J. LITCHFIELD   19th. Informatic harmofilestonic (Type, Print)   19th. Making Address (Street and Number or Plans Rocke Number). Cyp or Town, State, 2p Code)   19th. Informatic harmofilestonic (Type, Print)   19th. Making Address (Street and Number or Plans Rocke Number). Cyp or Town, State, 2p Code)   19th. Informatic harmofilestonic (Type, Print)   19th. Making Address (Street and Number or Plans Rocke Number). Cyp or Town, State, 2p Code)   19th. A PLAN LL	C Region				
20. Method of Disposition 1. Burier 2. 28Cremation 3 Disp	Be vot in	A Company of the Comp	18. Mother's Na	ma (First, Middle, Maiden Sumame	3)
20. Method of Bisposition 1. Buriet 2. 28C remarks or core places 2. Downston of Disposition 1. Buriet 2. 28C remarks or core places 2. Downston of Disposition (Plane of Carear Service Location - City or Form, State 4. Donation - Significant Control - Carear Service Location - City or Form, State 4. Donation - Significant Control - Carear Service Location - City or Form, State 4. Donation - Significant Control - Carear Service Location - City or Form, State 4. Donation - Significant Control - Carear Service Location - City or Form, State 4. Donation - Significant Control - Carear Service Location - City or Form, State 4. Donation - City or Significant Control - Carear Service Location - City or Carear Service L	Men Men To	CHARLES L. LITCHFIELD			
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Tile Fair   28 Committed   1   28 Committed   28 Committed   29	end ealth n 27	KATULEEN HOlly RADDATZ	1865 CHURCH Rd.	BA1to Md. 212	22
Physician / Medical Examinor  Physic	Pes 1	20a. Method of Disposition 20b. Pla	nce of Disposition (Name of metery, crematory or other place)	Date 20c. Location - 0	City or Town, Stata
Physician / Medical Examinor  Physic	Pag mit: I	4 □ Donation 5 □ Other (Specify) G'PI	EENMOUNT COM.	1 1/2000 BALTI	Md.
Physician / Medical Examinor  Physic	porti	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	FULLOOPE HOME	CHTD.
232. PART. Enter the diffusible, or configlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflavorable between minor of block in this or the mode of dying, such as cardiac or respiratory arrest, inflavorable between minor of block inflavorable between minor of b	D &&EE8	16 11/1/2011	HARTZEY MILLEN	01 12 101	
Physician Medical Examiner    Part   Content and Death   Content and Content and Death   Content and Content and Content and Content and Death   Content and Conte		23a. Part1. Enter the disease, or complications that caused the death.	Do not enter the mode of dving, such as cardia	ac or respiratory arrest.	Approximata
Due to (or as a consequence of):    Due to (or as a consequence of):	Physician	shock, or haart failura. List only one cause on each line.			Intarval Batween
Due to (or as a consequence of):    Scalar   Due to (or as a consequence of):		Immediata Causa (Final		,	
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate course. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause contribute to the cause of death?    Due to (or as a consequence of):		disease or condition resulting in death)		chan	<u> </u>
Cause (Disease or Injury that imflied events resulting in death) Last  Due to (or as a consequence of):    Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in death) Last   Cause (Disease or Injury that imflied events resulting in the underlying cause given in Part I.	ē		as a consequence of):		
Cause (Disease or Influt) That inflited events resulting in death) Last  C. Due to (or as a consequence of):  d  Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Vee 2   No 3   Probably 4   Chinknown and the contribution of cause of death?  1   Vee 2   No 3   Probably 4   Chinknown and the contribution of cause of death?  24a. Was an autopsy performed?  25. Was case referred to medical solution of cause of death?  25. Was case referred to medical look and the contribution of cause of death?  26. Place of Death (Check only one)  27. Menner of Death Lackdent   Nursing Home 5   Residence 6   Other (Specify)  28. Deat of Injury at Mook?  28. Place of Injury at Mook?  28. Death of Injury at Mook?  28.	min min	b			
Cause (Disease or influing)  And Department of the control of the	y xecu al-tra	Sequentially list conditions, if any, leading to immediate	as a consequence of):		
Description of the contribution of death but not resulting in the underlying cause given in Part I.    23b. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Chiknown   24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No 1   Yes 2   No 2	buni buni	Cause (Disease or injury			
State   Stat	phys the	resulting in death) Last Due to (or a	as a consequence of):		
State   Stat	ding sa e				
State   Stat	to date				1
State   Stat	ys.	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23b. Did tobacco use con	tribute to the cause of death?
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State   Stat	iras iras da be da be			and the state of t	Oth Man automy findings
Light atural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   5   Pending investigation   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.   29b. Signature end title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   31. Date filled (Month, Day, Year)   32. Segistrar's Signature   33. Date filled (Month, Day, Year)   32. Segistrar's Signature   33. Date filled (Month, Day, Year)   34. Date filled (Month, Day, Year)   34. Date filled (Month, Day, Year)   35. Segistrar's Signature   35. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   1	requirement of the state of the				available prior to
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Light atural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   5   Pending investigation   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.   29b. Signature end title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   31. Date filled (Month, Day, Year)   32. Segistrar's Signature   33. Date filled (Month, Day, Year)   32. Segistrar's Signature   33. Date filled (Month, Day, Year)   34. Date filled (Month, Day, Year)   34. Date filled (Month, Day, Year)   35. Segistrar's Signature   35. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   35. Segistrar's Signature   15. Injury   M.   Month, Day, Year)   1	The The Co			1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
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1	y sic y sic dire dire		R/Outpatient 3 DOA Other: 4 Nursing !	Home 5 ☐ Residence 6 ☐ Othe	or (Specify)
2   Accident 3   Suicide 4   Homicide   28a. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   32. Segistrar's Signature   31. Date filed (Month, Day, Year)   32. Segistrar's Signature   32. Segistrar's Signature   33. Date filed (Month, Day, Year)   32. Segistrar's Signature   33. Date filed (Month, Day, Year)   34. Certifier   29c. License number   29d. Date signed (Month, Day, Year)   32. Segistrar's Signature   34. Certifier   29c. License number   29d. Date   2	G Ph	27. Manner of Death 28a. Date of Injury 2	28b. Time of 28c. Injury at Work?	28d. Describe how injury occurre	be
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature end title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bruce of the cause(s) and manner as stated.  (Check only one)  29a. Certifier (Check only one)  29d. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bruce of the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	atic atic	2 Accident investigation			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature end title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bruce of the cause(s) and manner as stated.  (Check only one)  29a. Certifier (Check only one)  29d. Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bruce of the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	And	determined   20a. Place of injury - At nort	ne, farm, street, factory, office		er or Rural Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature end title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bry (Ex. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Bry (Ex. Medical Carter Balter May 21724)  31. Date filed (Month, Day, Year)  32. State  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	Series of Deriver	building, etc. (Specify)		City or Town, State)	
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  BAYLIEN Medical Center Balto ms 21224  State  31. Date filed (Month, Day, Year)  32. gegistrar's Signature	houn houn y fille	29a. Certifier ,12 Certifying Physician: To the best of my knowl	ledge, death occurred at the time, date and place	e, and due to the cause(s) and mar	nnar as stated.
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  BAYLIEN Medical Center Balto ms 21224  State  31. Date filed (Month, Day, Year)  32. gegistrar's Signature	P Fu	(Check only one)  2 Medical Examiner: On the basis of axamination and manner stated.	on and/or investigation, in my opinion, death occ	urred at the time, data and place, a	nd due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BAYVIEW Medical Contin Balto MB 21224  State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature	To the Company of the		29c. License number	29d. Date signed	(Month, Day, Year)
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  Bayview Medical Center Balto ms 21224  State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature		Alital Chill . a.	8	000	1 2000
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State of Maryland / Department of Health and Mental Hygiene 14524 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** George Leroy Foreman May 2000 1:50PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2006 Whistler Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
| Dave Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. 219-20-5000 73 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Medical Examinan must be notified at No Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 2006 Whistler Avenue USA 21230 12. Wes Decedent Ever in U,S.
Armed Forces?'

1 □Xes 2 □ No
If Yes, Give
Year or Dates: ₩₩ I I Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. o filed within 72 hours efter de I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Serviceman Printing Machines permit. Peges 1 end 2 should be file. Depertment of Health end Mentel Hyg Important: If Item 27 Is marked other any injury or other traumatic event, DRCB. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Foreman Mabel Cavanaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2006 Whistler Avenue Baltimore, MD 21230 Thelma Agnes Foreman/Wife 20b. Place of Disposition (Name of competery, crematory or other place)
Maryland VA Cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/00 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Garrison Forest 21. Signature Funeral Service Lige 22. Name and Address of Facility
MacNabb Funeral Home, P.A. Gregorchik Edward A. duta & A 301 Frederick Road Catonsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final . Metastatic Colon Cancer disease or condition resulting in death) Examiner Examiner physicien end the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Hupertensive Atherosileratic Cardious wher Dais 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24e. Was en eutopsy performed? Drabetes mellitis - Type II 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To his 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funere 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Whete Dut si May 3, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 E. Fort tup. Bultimore MD 21230 Robert Durt 31. Date filed (Month, Day, Year) 32. Registrar's Signatura MAY 0 5 2000 Registrar

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State of Maryland / Department of Health and Mental Hygien® () Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death Month 092 **Physician** French nuntera /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deetl Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Dey, Year) April 17,1935 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours XXM 2DF 213-32-0384 65 Yrs. Director Mary land Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or flems 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at XXYes 2□ No Director Anne Arundel Annapolis 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 518 Ridgely Avenue 21401 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 22 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Black, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours after Department of Haalth end Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercise. 1 Never Married XX Married 3altimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Automotive Parts Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 36 Munford William Arthur French Bertha Catherine Clow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary G. French (Wife) 518 Ridgely Avenue, Annapolis, MD 21401 20e. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 05/05/ cemetery, cremetory or other piece) 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Cemetery 2000 Annapolis, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Cerebrovasular accident /Medical Immediete Causa (Final disease or condition resulting in deeth) Examiner endocarditis Value Examiner Hortic physician end s the burial-transit certificate be executed Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initioted events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): 88 950 P.0. Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Division of Vital Records. þ 24b. Were autopsy findings aveilable prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed page 2 s has 200 1 Yes 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes case referred to medical 26. Placa of Death (Check only ona) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital; 2 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury et Work? To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification: 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Neturel 2 Accidant Injury 5 Pending 1 ☐ Yes 2 ☐ No investigetion 3 Suicide 6 Could not be determined Location (Street and Number or Rurel Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To Certifying Physician: To the best of my knowledga, daath occurred at the tima, date and placa, and due to tha ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at tha tima, date and place, and due to the ceuse(s) and menner stated. 29e. Certifier 29c. License numbar 29b. Signeture and fittle of certifier 29d. Date signed (Month, Dey, Year, who,completed cause of deeth (Item 23a) (Type, Print) Neme end address of person 05 32. Registrer's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® () Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth 3 Time of Death 3:30 pm ELIZABETH Η. FEEHLEY May 2,2000 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth 502 S. DECKER AVENUE BALTIMORE If Under 24 Hrs. 8, Det N/AIf Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Sept. 19,1915 Birthplece (State or Foreign Country)
 MARY LAND 6. Sex 10 M 20XF Months Deys Hours 84 Yrs. Sept. 168-30-0351 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1)CYes 2 □ No MD N/A BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 502 S. DECKER AVENUE 21224 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Merital Status 1 Never Merried 2 Merried 1 Yes 2XXNo Specify: 3 ☑ Widowed 4 □ Divorced Year or Detes: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 HOUSEWIFE DOMESTIC 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) GEORGE HORNER ANNA GEHRMAN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) DOROTHY GRUNDAHL/ DAUGHTER 502 S. DECKER AVENUE, BALTIMORE, MARYLAND 21224 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1XXBurial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY 5/6/00 BALTIMORE, MARYLAND 21. Signetura of Funeral Service Licensee 22. Name end Address of Fecility LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) 3mon741 Tarredie Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed

8

10a, State

**Funeral** 

Director

28a-1

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"natural", or items

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 2008.

the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Physician/Medical à Be

physician and s the buriei-transit The law requires that the death certificate be executed signed by it this After this

Division of Vital or Attending Physician: efter death.
Director: Aff filled in 24 hours Hospital To the Hosp within 24 hor To the Fune completely fi

State

DHMH 16 Rev 6/95

Examiner Completed Certification: To

25. Wes case reterred to medical

1 Yes 2 No

27. Manner of Death

Neturel

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

MAY

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, In my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29b. Signeture end title of certifier 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) MICHARL URRII

2000

5 Pending investigation

6 Could not be determined

05

Hysician

32. Registrar's Signeture

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

JYBVML 4940 EXTEN AVE

28c. Injury at Work?

29c. License numbe

1 Yes 2 No

BALTIMIOR

1 ☐ Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Pasidence 6 Other (Specify)

1 ☐ Yes 2 No

Registrar

MAY DE JOY MAN

Piease Type or Print in Biack indelible ink. Assure All Copies Are Legible. AMEND ITEMS: #13, 19B PER F.H. G783 5-5-00 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Maria Gonzalez May 2000 18:03 /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F Months Director 053-22-4597 Puerto Rico Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryle Department of Heelth and Mentel Hydene. Important: If item 27 is marked other than "naturat", or items 23s or 28s-1 show any Injury or other traumatic avant, the Medical Examiner must be notified as page. Puerto 1 2 Yes 2 □ No Director N/A Carolina 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? Exp. Villamar Street 4EO-113 00979 USA Funeral 12. Was Dacadent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 No Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian. 11. Maritel Status Black, White, etc. PUERTO RICO

Specify: Prince in a state of the state of 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: Specify: Puertican þ 3 Widowed 4 Divorced **Puertican** Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completad) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Domestic 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Francisco Gonzales Rosario Mulet 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) (10979) Rosario Martinez Gonzales/Daughter Exp. Villamar St.4EO-113 Carolina, Puerto Rico 0097 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Puerto Rico Memorial 5/5/00 4 ☐ Donation 5 ☐ Other (Specify) Puerto Rico 21. Signature of Funeral Service Licensea 22. Name and Addrass of Facility David J. Weber Funeral Homes, P.A. 401 S. Chester St. Baltimore, Maryland 21231 Approximate Intervel Between Onset end Death 23a. Pert1. Enter the disees of or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Rheumatic Heart Disease 20 years Examiner Due to (or es a consequence of): Examiner Coronary Artery Disease 10 years The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as e consequence ot) ettending physicien for use es the buris Left Ventricular Hypertrophy 10 years Physician/Medical Due to (or as e consequence of) use es signed by the eld be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Bypass Graft by 24b. Were eutopsy findings aveilable prior to completion of cause ot deeth? Completed 24a. Was en eutopsy performed? Aortic Value Replacement certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours after deeth.
 Funeral Director: After this certificaletely filled in by the funerel director, 25. Was case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) examinei : 1. Yes 2 □ No Hospital: 1 Anpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

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Registrar

**DHMH 16 Rev 6/95** 

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31. Dete tiled (Month, Day, Year)

29a. Certifier

(Check only one) 29b. Signature a

> 600 N. Wolfe Street- Baltimore, Maryland 21287 Daniel Meldrum 32. Registrar's Signature

1 XCertifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) and menner steted.

29c. License number

128260

29d Date signed (Month, Day, Year)

4,2000

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yaai **Physician** GERS HeD7 bm EDNA 2000 HAZEL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner N/A Baltimne Hos brital Dinau If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Yrs. 220-30-2484 86 12-20-1913 Director VA Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Merylend nent of Heelth and Mantel Hygiene. ant: if Item 27 ie marked other than "natural", or items 23s or 28s-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hem 27 is marked other than "natural, or flems 23s or 28s-f show other traumatic event, the Medical Exprision must be notified at MD. BALTIMORE OWINGS MILLS 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 DURUM CT. 21117 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -8--0-HOUSEKEEPING DOMESTIC 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALEXANDER RAGLAND LAURA TUCK 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONDRA HINES (GRAND DAUGHTER) 8 DURUM CT. OWINGS MILLS, MARYLAND 21117 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: if Its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 5-6-2000 BALTIMORE, MARYLAND 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. of Suneral Se 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue use as the burial-trar Due to (or es a consequenca of) signed by the attending physician d be detached for use as the buna Due to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by Were autopsy findings available prior to completion of cause of death? should 24a. Was an autopy this certificate has page 2 2 PNo 1 Tes 1 Yas 2 No Attending Physician: director. 25. Was case reterred to redical examiner? Be 26. Place of Deeth (Check bnly one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA al or Atte.

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by the funer. 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours
To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number

State Registrar

31. Date tiled (Month, Day, Year)

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32. Registrar's Signature

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July, Year) 32. Hegistrans Signa

WHO S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** Joseph P. Garvey 27, 2000 10:40 pm April /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8904 Ornwood Lane Laurel Prince George If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** Days XXM 2□ F 78 Yes 048-10-2042 Director Feb. 3, 1922 Connecticut Usual Rasidence of Decedent permit. Peges 1 and 2 should be filled within 72 hours effer deeth with the Meryland Department of Health and Mentel Hygiene. Important: if Item 27 is merked other than "natural", or Items 23s or 28s-f show any injury or other traumstic event, the Medical Experience. 10a, State 10b. County 10c. City, Town or Location niel Hygiene. 3d other than "netural", or Itema 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Insida City Limits MD Prince George Laure1 1 ☐ Yas 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8904 Ornwood Lane 20708 U.S.A. Funerai 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Types 2 No If Yes, Giva Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: White Specify: Completed by 3D(Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Government Military 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrick J. Garvey Minnie Strauss 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14740 4th Street, Apt 103B Laurel, Maryland 20707 Joseph E. Garvey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Arlington National Cemetery -4-00Arlington, Virginia 21. Signature of Fune 22. Nama and Address of Facility Fleck Funeral Home Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, 23a. Part1. Enter the dis Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) Prostate Cancer 8 years Metastatic Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The lew requires that the deeth certificate be executed the bunel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2 No 3 Probably 4 Unknown s been signed to should be det Division of Vital Records, Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete 1 ☐ Yas funeral director, 25. Was casa rafarred to medical axaminar? 8 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Othar (Specify) Medical Certification: To 1 ☐ Yas 2 🕽 📢 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of fnjury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 5 Pending investigation After 1 Natural 2 Accident n 24 hours after death.

Ne Funerel Director: After pletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

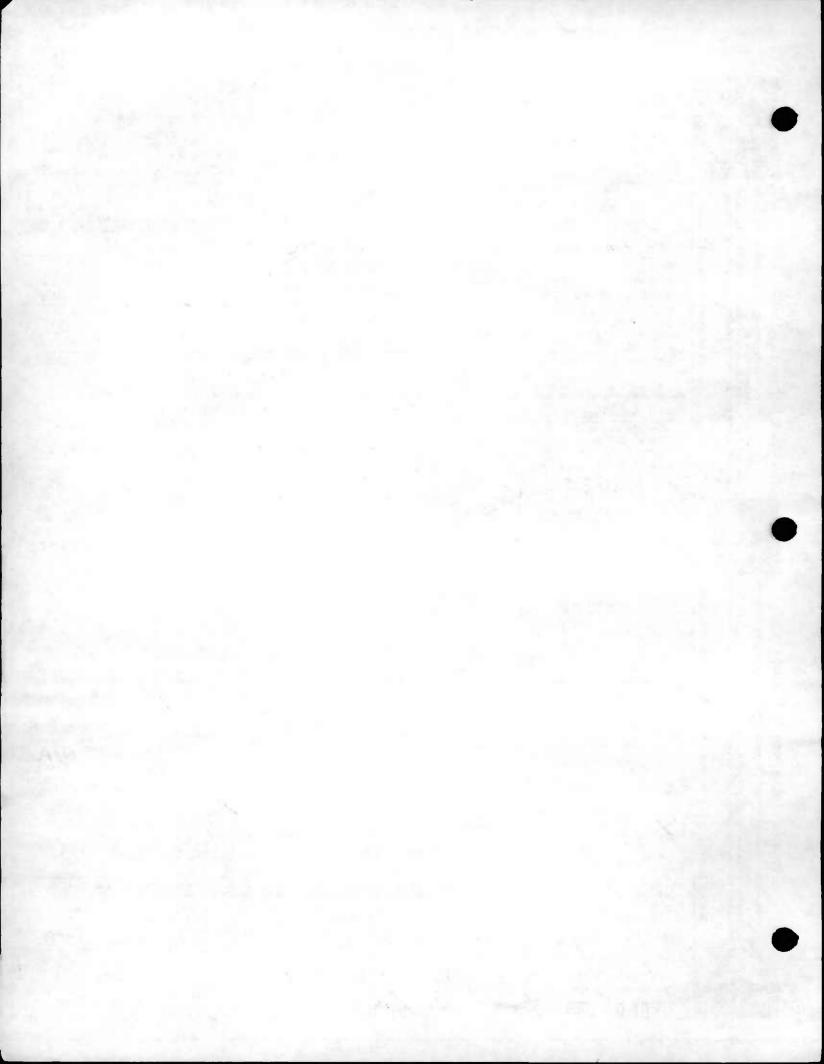
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) Vithin 2, \$ 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 00031586 auson M.D. 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) MD, 22 South Greene St, Battimore, MD Dawson Univof

State Registrar 31. Data filed (Month, Day, Year)

MAY 0 5 2000

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32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Yaa **Physician** 0105A 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** H Undar 24 Hrs.
Hours Min.
Dec. 23, 1908 If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2 F Days Months Yrs. 217-12-1996 91 PA. Director Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar natal be notified at 1 Yas 2 No Director Baltimore Dundalk 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 1929 Midland Rd 21222 USA Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 Yas 2 No Specify: 3altimore, Maryiand 21215-0020 Specify: þ White 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mentel Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 yrs. Supervisor Western Electric 17. Fathar's Nama (First, Middla, Last) permit. Peges 1 end 2 should be file Department of Health end Mentel Hy Important: If Nem 27 la marked oth any Injury or other traumatic event 18. Molhar's Nama (First, Middla, Maidan Surnama) Be 2 Evan Shuster Francis Begovic 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) William Harper son 80 Canvas Back Rd. Selbyville, De. 19975 20e. Method of Disposition 20b. Plece of Disposition (Neme of camatary, cramatory or other pleca) 20c. Location - City or Town, Stata May 6, 1 Burial 2 Cramation 3 Ramoval from Stata Oaklawn Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 2000 Dundalk, MD. 22. Nama and Address of Facility
Connelly Funeral Home of Dundalk, P.A. 21. Signature of Fundal Sarvice License 7110 Sollers Point Rd. Dundalk, Md. 21222 ry Enter the diseese, or complications that caused tha death. Do not anter the mode of dying, such as cardiec or respiratory errest, or heert failure. List only one cause on each line. **Physician** Immedieta Ceusa (Final diseasa or condition rasulting in death) /Medical Congestive heart failure ten years Examiner Examine physician and s the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequanca of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Chronic obstructive pulmonary Division of Vital Records. by 24b. Wera autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy Completed 21/2 No 1 🗆 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient ②KI\_ER/Outpatient 3☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 0 1 Vas 2 No 28c. Injury at Work? 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: or Attending Fattar deeth. 5 Pending investigation Neturel Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be datarmined 3 ☐ Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straal, factory, office building, atc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Phyelcian: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, dete and place, and dua to tha ceuse(s) and mannar stetad. 29a. Certifiar edical (Check only one) To the To the To the 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) Michael Westerman 1.D. 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 5505 Hopking Balquiew Circle

Registrar **DHMH 16 Rev 6/95** 

State

31. Data filed (Month, Day, Year) MAY 0 5 2000

Michael Westerman, M.D.

32. Registrar's Signatura

Elder Housecall Program 21224

Maryland

Baltimore.

hours to sports

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State of Maryland / Department of Health and Mental Hygiene

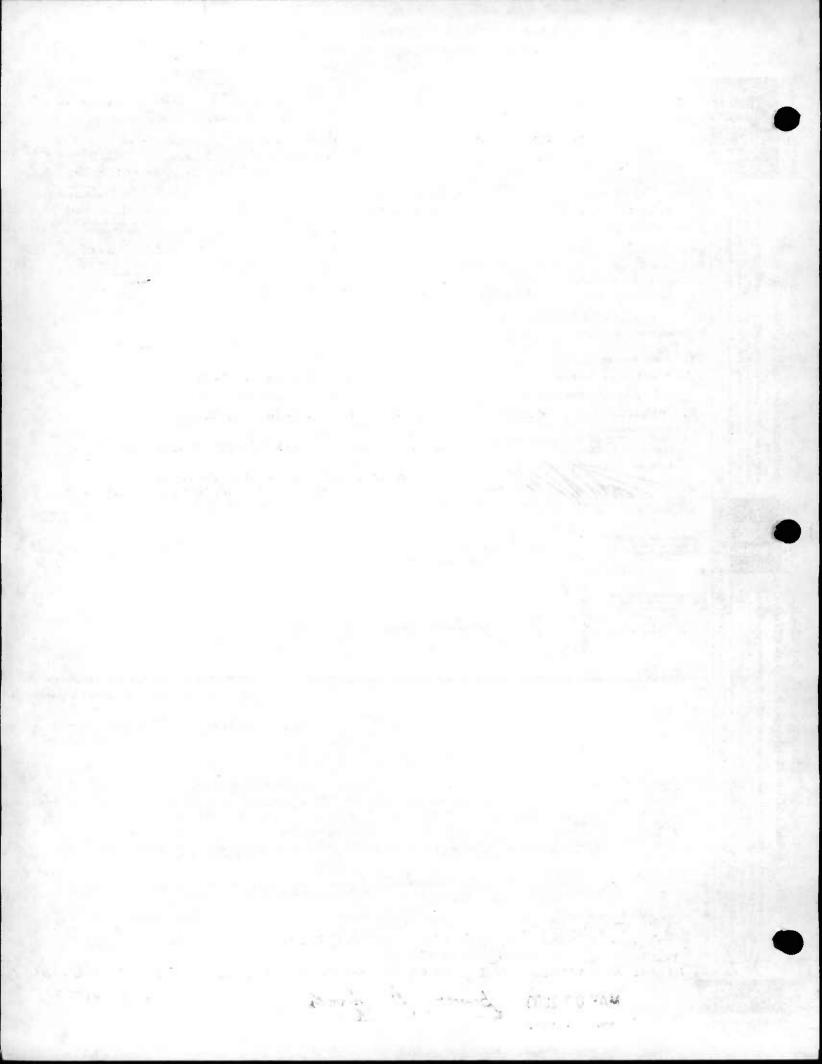
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Paul R. Hawse May 2 2800 10:40 AM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Nursing Center Carrol1 Westminster 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 if Under 24 Hrs. 7. Age (In yrs. lest birthday) Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 220-28-9298 65 Yrs. Director 1935 Maryland April 2, Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentai Hygiene.
Important: If Item 27 is merked other than "naturs!", or frems 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b County 10c. City. Town or Location 10d. Inside City Limits Maryland Carroll 1 ☐ Yes 2 No Director Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 608 Oak Tree Rd. 21157 Funeral United States 11. Maritai Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 TXYes 2 No 1953-If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 CXNo Specify White à 3 ☐ Widowed 4 ☐ Divorcad Year or Detes: 1955 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence W. Hawse Mildred E. Thompson 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jean Marie Hawse (Wife) Rt. 1 Box 65, Ridgeley, WV 26753 20e. Method of Disposition 20b. Pieca of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Lake View Memorial Park 5/5/00 Sykesville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral S 22. Neme end Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final ro Vascular Disease disease or condition resulting in death) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Lest attending physician and for use es the burial-trar Due to (or es e consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the s should be deteched 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à Completed 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? pege 2 s certificete 1 ☐ Yes 2 ☐ No Division of Vital director Be 25. Wes case referred to medical 26. Piece of Death (Check only one) 1 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28e. Dete of Injury (Month, Day Year) 27. Mayiner of Death Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Natural 5 Pending efter death.

Director: Aft
d in by the fur 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in the Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 0 Name and eddress of person who completed caute of deeth (Item 23e) (Type, Print) Union Bridge Rd Box 779 New Windson, 4 Land MD 21776 ames torsbe m 1233 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) State MAY 05 2000 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 14532 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death William Physician Juhnson Arnold 2000 Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore DICE MONLUM If Under 24 Hrs. 8. De If Under 1 Year Months Days curity Number 6. Sex 7 Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Gountry) Funeral Days 112M 2□ F 216-42-422 Usual Residence of Decedent Hours Min 09 10 1944 Maryland 10a Stata 10b. County 10d. Inside City Limits ahow 10c. City. Town or Location 1 Tes 2 No Director Md haturel', or herre 23e or 28e-f dicel Exeminer must be notifie saltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1521 Northwic SA Funeral 'naturel', or items 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after (Degartment of Health and Mental Hygienn. Important: If Item 27 is marked other than "natural", or has any injury or other traumatic event, the Medical Examinations. Black, Whita, atc. African 1 Never Married 2 Married 1 DYes 2 No If Yes, Give Yaar or Datas: Saltimore, Maryland 21215-0020 1□ Yes 2ETNo Specify: à 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bagel Baker 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 8 2 atherine Ohnson E. Johnson 19a. Informant's Name/Ralationship (Type, Print) (515) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1521 Northwick Rd. Baltimore, md. 21218 Mrs. Roberta 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 Removal from Stata Garrison 4 ☐ Donation 5 ☐ Other (Specify) Dwings Mills Mo tored 27. Name and Address of Facility 21. Signature of Funeral Service Licensee uneral Home JOSEPH 2222 w. north uss Balto, md. 21216 23a. Fert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Cancer Immediate Cause (Final und disease or condition resulting in death) Examiner Dua to (or as a consequence of): burlai-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of). strending physicien for use as the burle Records, P.O. Box 68760. The law requires that the death certificete be Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 1. Whiknown ģ 24b. Were eutopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy certificate 1 Yas 2 IN 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Dether (Specify) HOJNICE edical Certification: To 1 Yes 2 No 1 al or Attanding Physics after deeth.

I Director: After this be in by the funeral d 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Tima of 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number 14/00 D43725

State Registrar

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year) MAY 0 5 2000

TARIQ MAITMOOD

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

MD. 2300 Dylancy Vallay Rd.

32. Begistrar's Signeture

Timonium MD21093

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Day Year **Physician** James 29, Jones 11:00 a.m April 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. last birthday). 73 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sev Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□ F 250-40-0871 Director Feb. 28, 1927 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits n/a Baltimore Md. To Yes 2 □ No Director 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8 1600 W. Mt. Royal Avenue Apt. 1415 USA ns 23a Funera 12. Was Dacedent Evar in U,S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Marriad 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Arrow Crown Elemantary/Secondary (0-12) College (1-4or 5+) Window Cleaners 12th Grade Janitor Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill fealth and Mental H Be unknown Bertha Jones 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2720 W. Country Club Road Philadelphia, PA. 19131 19e. Informant's Name/Reletionship (Type, Print) James L. Jones Jr. son Health ( Pages 1 ament of He 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Struial 2 Cremation 3 Removal from Stete Arbutus Memorial Park May 5 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Gerber 23a. Part1. Enter the diseasa, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Death **Physician** A there scleratio Cardio varubs di sease Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760, that initiated events rasulting in death) Lasf Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed be should be deta Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To the state of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. completaly (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29c. License number **D** 17537 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOUNT Royal Are, Bulto 21217
DARSHAN, S. SALU/A MD 1600 W. MOUNT Royal Are, Bulto 21217 31. Date filed (Month, Day, Year)

Registrar

MAY 0.5.2000 **DHMH 16 Rev 6/95** 

32. Registrar's Signature

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 534 State of Maryland / Department of Hanks

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March March

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 22:28 2000 WA 4c. County of Deeth 4b. City, Town, or Location of Death BAHO If Under 24 Hrs. Hours Min. 1708 7. Age (In yrs. last birthday) lemoriA) If Under 1 Year Birthplace (State or Foreign Country) Months 1□ M 24 F 2760 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Marrie 1□ Yes 2 No 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ome wor Home MAKER grade 0 18. Mother's Name (First, Middle, Maiden Sumeme) 's Neme (First, Middle, Last) LOY nex 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Neme of cametery, cremetory or other place) BATTO. M. 21205 monument St. 20c. Location - City or Town, Stete urial 2 ☐ Cremetion 3 ☐ Removel from State Diretion 5 ☐ Other (Specify) IAWA 21. Signeture of Furieral Service Licensee 23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 34170. mo.2/2/3 Hour Immediate Cause (Final ACUTE MYOCARDIAL INFARETION disease or condition resulting in death) ORONARY ARTERY YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last RENAC STAGE YEARS. YPERTENSIXX Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Pronknown MECLITU 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? INFECTION 1 Yes 2□No 1 PYes 2□ No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificete be axecuted Box 68760 P.0 of Vital Records, us after death.

ours after death.

ours after death.

erel Director: After this certificate has been si
filled in by the tuneral director, page 2 should Division

**Physician** 

/Medical

Examiner

Funeral Director

Be Completed by

**Funeral** 

Director

ahow.

Nem 27 is marked other than "natural", or itema 23a or 28a-f sho other treumatic event, the Medical Examinar must be notified at

"netural"

Department of Haalth end Mental Hygiene.

**Physician** /Medical

Examiner

Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death

Maryland 21215-0020

altimore,

þ Completed 25. Was case referred to medicat examiner? Certification: To Be 1 Yes 2 No 27. Manner of Death 1 Maturet 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical

29a. Certifier (Check only one) 1 Decrifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifig

29d. Date signed (Month, Dey, Year) 29c. License number

Thulagori

D0015

05-03-00

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) CARLOS M. ORREGOSO

State Registrar

31. Dete filed (Month, Day, Year)

MAY 05

MONORIAL HOSPITAL UNION 32. Registrer's Signeture

**DHMH 16 Rev 6/95** 

To the Hospital of within 24 hours a To the Funeral D complately filled in

**ORIGINAL** 

was the in some or

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20:05 April 28 2000 Frank J. Lina /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Worchester Berlin
If Under 24 Hrs. Atlantic General Hospital If Under 1 Year Date of Birth (Month, Dey, Yeer) Aug. 24, 1925 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 M 2 □ F Yrs 74 Director 218-16-1000 Enhaut, PA Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show item 27 is merked other than "natural", or items 23s or 28s-f sho other traumatic event, the Medical Expanding must be notified at 1 Ves 2 No Director Worchester Ocean City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? DOB 306 140th Street 21842 LISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. 1 N Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: Specify: by white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 ntaf Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service 12 years mail carrier 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be and Mantai Frank Jacob Lina Sr. Helen Bauman pluods 00/82 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Theresa M. Lina (wife) 306 140th St. Ocean City, MD 21842 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State parmit. Pagas Department of H Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetary 5/2/2000 Baltimore, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility E.F.Lassahn Funeral Home 4. Lassa 11750 Belair Rd. Kingsville. MD. 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset and Death **Physician** Mesotheliona /Medical Immediate Ceuse (Final disease or condition resulting in death) 3 months Examiner Due to (or es a consequence of) Examiner JUMONIA The law requires that the death certificate be executed physician and strans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai that initiated events resulting in death) Last Due to (or as e consequence of): usa signed by the aid be datached for 23b. Dfd tobecco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? s cartificata has b 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 No 1 ☐ Yeys 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To this funaral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Naturel 2 Accident aftar daati Director: To the Hospital or Atterwithin 24 hours aftar day
To the Funeral Director
complataly filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Dr Borlin Mo ISSHER 133 Heelthway 31. Dete filed (Month, Day, Year)
MAY 0 5 2000 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

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Name of the second seco

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer Month LAFLAME ILDRED 8:30 am MAY 03 2000 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HOSPITAL OF BALTIMORE SAMARITAN GOOD BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Deys Hours 1 ☐ M 2 [XF 90 11/29/1909 220-34-6563 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3129 HIss Avenue 21234 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2000 Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housework Self Employed 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Charles Inglis Elizabeth Faber 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Lawrence LaFlame 3129 Hiss Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Gardens of Faith Cemetery5/6/00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility John C. Miller Inc. 21. Signeture of Funeral rvice Licensee 6415 Belair Road Baltimore, Maryland 21206 disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, feilure. List only one cause on each line. 23a. Pert1. Enter to shock, or heart Approximete Intervel Between Onset end Death Immediate Ceuse (Final SEPSIS disease or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or inJury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or as e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes > No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner requiras that the death certificate be axecuted Records, P.O. Box 68760 or Attending Physician:

physician and the bunal-tran usa as t attending p ed by the a 8 page 2 s cartificata has Division of Vital this funeral After s after death. in by To the Hospital o within 24 hours af To the Funeral D completely filled i

**Physician** 

/Medical

Examiner

Director

Funerai

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Completed

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Examiner

Physician/Medical

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Certification:

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**Funeral** 

**Director** 

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f ahow any Injury or other traumatic event, It a Machael Exercise.

**Physician** Necical

> State Registrar

31. Dete filed (Month, Day, Year)

29b. Signature end title of certifier

Manisha Bah

BAHL

32. Registrer's Signature

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

M.D

GOOD SAMARITAN HOSPITAL borto

Certifying Phyelcian: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated.

29c. License number

13452

5601

29d. Date signed (Month, Dey, Year)

03

BALTIMORE, MARYLAND 21239

LOCH RAVEN BOULEVARD

2000

MAY

MANISHA MAY 0 5 2000

4 ☐ Homicide

(Check only one)

29a. Certifier

MAY 05 July 1

00-2376-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene-Alvin Marsh 28A-F PER MEO Certificate of Death AMEND ITEMS: #23 PART I, 27 Reg. No. edent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** Marsh 29, 2000 1:53 P.M. April /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Maryland General Hospital Baltimore N/A 8. Dete of Birth (Month, Dey, Year) 05-30-1966 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Deys Months 10 M 20 F Hours 2 220-86-4998 Yrs. Mari Director Usual Residence of Decede 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location Berns 23s or 25s-f show 1 Tes 2 No Director altimore 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number 14. Race - American Indian, Black, White, etc. Funeral Bak 17 6 13. Was Decedent of Hispanic Origin? (Specify Yas or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forces? 11. Meritel Status hours after 1 Yes 2 Z If Yes, Give Year or Dates: 1 Never Merried 2 Merried 2 1 No specific Frican natural, or altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced American Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) aborer Higeneles 1em porary permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy.
Important: If Item 27 is marked others any Injury or others. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McKenny Rosa Marc 2 Ernes 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 675 Mrs Rosa McKenny Bakburi Md HIMOre 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State Dete 20a. Method of Disposition cemetery, cremetory or other plece) 1 1 Burial 2 □ Cremation 3 □ Removel Irom State 4 ☐ Donation 5 ☐ Other (Specify) ansdrune 21. Signatu of Funeral Service Licenses Address of Russ Funeral Home Baltimore Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final NARCOTIC INTOXICATION disaase or condition resulting in death) Examiner Due to (or es e consequence of) Examine sician and buriat-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thal initiated events resulting in death) Last Due to (or es e consequence of): attending physician Box 68760 certificate be Physician/Medical the t Dua lo (or es e consequence ol): 88 esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed if or Attending Physician: The law after death.

Director: After this certificate has I d in by the funaral director, page 2.9 1 Yes 2 No Yes 2 No Division of Vital Be 25. Wes cese referred to medical 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of P Certification: 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2√ No UNKNOWN 2 Accident Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1675 BAKBURY COURT filled in by 4 Homicide FOUND AT HOME BALTO. CITY, MD. 24 hours Hospital edical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the tima, date end place, end due to the ceuse(s) and manner steted.

State Registrar 29b. Signature and title

31. Dete

artifia

Day,

2000

05

To the within 2

no completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

estane(

29c. Licansa number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Dey, Year)

April 30, 2000

KAY 8 E E E E E

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Data of Daath 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month MAY **Physician** 2000 2, JOSEPHINE McKNIGHT 4:00am /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS ELDERCARE RANDALLSTOWN BALTIMORE If Undar 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Yaar) 11-18-1910 Birthplece (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ 2□ F Months Hours 89 247-18-3541 SC Director Usual Residence of Decedant 10c. City, Town or Location 10a State 10b. County 10d. Insida City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yas 2 ☐ No Director BALTIMORE RANDALLSTOWN 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 3615 TEMPLAR RD. 21133 USA Funeral Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forces? 11 Marital Status 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: hours efter 1 Navar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: BLACK à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Peges 1 end 2 should be filed within Department of Heelth end Mentel Hygiene. Important: If Item 27 Ia marked other than any Injury or other traumetic event, the Mentel Information or other traumetic event, the Men Elamantary/Secondary (0-12) College (1-4or 5+) LABORER DISTRIBUTION 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be CYRUS PATTON PEARL HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 3615 TEMPLAR RD. RANDALLSTOWN, MARYLAND 21133 PEARLENA BERNARD (DAUGHTER) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 5 Sother (Specify) ENTOMBMENT 4 Donation ARBUTUS MEMORIAL PARK 5-5-2000 BALTIMORE, MARYLAND 22. Nama and Addrass of Facility PHILLIPS FUNERAL HOME, P.A. ce License 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haert failure. List only one cause on each line. Physician /Medical immediate Ceuse (Final disaasa or condition resulting in daath) Examiner Examiner physicien end s the buriel-transit Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Ceuse (Diseese or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): physicien Box 68760 Physician/Medical Dua to (or as e consequance of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. the signed by t 1 ☐ Yes 2 ☐ No 3 Probably by Venal filme 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? Completed peen complation of causa of death? certificate hes 2 0 No 1 ☐ Yas 2 ☐ No 1 Tes 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatiant 3 DOA this 28a. Data of Injury (Month, Dey Year) 27. Manne of Death 1 12 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 To the Hospital or Attending is within 24 hours efter death.

To the Funeral Director: After 5 Panding invastigation s efter death.

I Director: Aft
d in by the fur 1 Yas 2 No 2 Accident 6 Could not be datamined 3 ☐ Suicide 28f. Location (Straat end Numbar or Rural Routa Numbar, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 | Homicide edicai 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and mannar es stetad. completely niner: On ha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, end due to tha cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) MI 30. Nama and and resstot person who co of daath (Itam 23a) (Type, Print) eman Begistrar's Signature 31. Data filed (I 32. State Registrar

**ORIGINAL** 

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** April 30 Dey 2000 Year Icie Dora Matthews 12:10am /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Lorien Nursing Home Columbia Howard 5. Sociel Security Number 7. Age (In yrs. last birthday) 90 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
J. Month, 22, Year 910 9. Birthplace (State or Foreign **Funeral** Deys Months Hours Min. 566-30-3445 1 □ M 2 13 F Alabama Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locetion 10d. Inside City Limits MD. Howard Columbia Director 1 ☐ Yes 2€No 10f. Zip Code 10a. Citizen of Whet Country? 9476 Old Deep Court 21045 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married black If Yes, Give Year or Dates: ρ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Ohio State Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed with Deportment of Health, and Mental Hygiene important: if them 27 is marked other that any injury or other traumetic avent, The JORG. University salad specialist 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Rowe Eliza Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Willie B. Bembry, daughter 9476 Old Deep Court, Columbia, Md. 21045 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place)
St. John's Cemetery 20c. Location - City or Town, State 5/6/00 Ellicott City, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Witzke Funeral Home, Inc. 5555 Twin Knolls Rd. enner Columbia, Md. 21045 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** Aspiration pneumonia wks Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** End Stage Parkinson's yrs Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of): iclan/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? Physi 3 Probably 4 Unknown No by 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy completion of ceuse of death? 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21X No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28c. Injury et Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Vatural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Box 68760. 99 P.O. Records. The Division of Vital

with the Maryland Show

death

a filed within 72 hours after de Il Hygiene. other than "natural", or Item

Baltimore, Maryland 21215-0020

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

bunel-tran. and physician the 80 ettending 9SF for ed by the e signed by t d be detect page 2 should certificete has this filled in by the funeral To the Hospital or Attending Phywithin 24 hours efter death.

To the Funeral Director: After the completely filled in by the funeral After 1

> State Registrar

edical

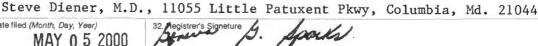
29a. Certifie (Check only one)

29b. Signature end title of certifie

31. Date filed (Month, Day, Yeer) MAY 0 5 2000

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

CULTOSS



12 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

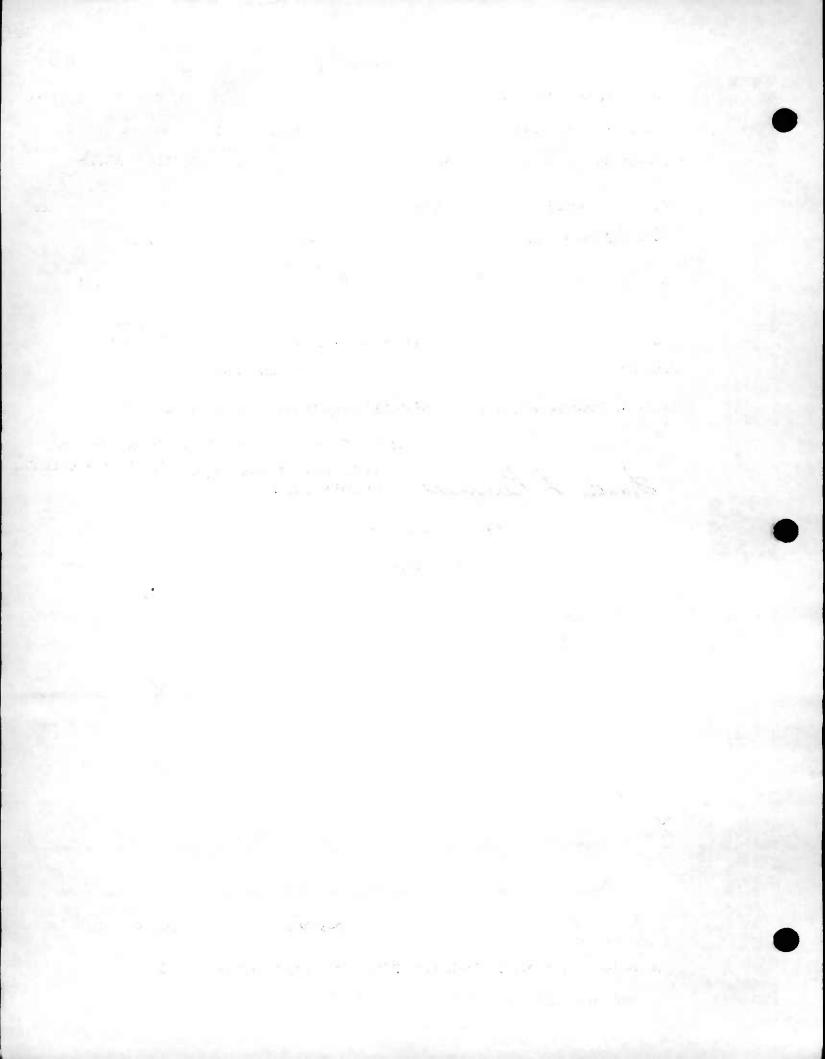
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29c. License number

D-34868

29d. Date signed (Month, Dey, Yeer)

May 4, 2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Otate of W	arylaria /	Certifica			Wentarry	Reg. No.	14	541	
Ne coloieu	1. Decedant's Nama (First, Middla,	Last)					2. Data of D	eath Day	Yaar	3. Tima of Death	
Physician /Medical	TOBATHIA				NEL	.son	MAY	2,20		16:48	
Examiner	4a Facility Nama (If not institution, g	iva street and number,	)			-	r Location of Dea		of Death		
	JOHNS HOPKIN	S HOSPIT	AL		1		ORECI	11	N/A		
uneral rector	218-28-7567	Sex 7. Ag	ga (In yrs. last b	Yrs. If Unc Month	dar 1 Yaar as Days	If Undar 24 Hr Hours Mir		ntt/ ay, Year) ., 1931	9. Birthple Count Mary	eca (State or Foraign ry) Land	
*	Usuat Rasidance of Decedent  10a, Stata 10b, County		10c City To	wn or Location					10	d. Insida City Limits	
or sho	Maryland N/A		1	timore						X Yas 2 □ No	
ect of	10e. Street and Number 10f. Zip Coda 10g. Citizan o								What Count	nv?	
important: I from 27 is marked other train in herbital Examiner must be notified at once.  any lojury or other traumetic event, the Hedical Examiner must be notified at once.  To Be Completed by Funeral Director	2021 East Nor	th Avenue			212		USA				
event, the Medical Examination  Be Completed by Fune	11. Mantal Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	If Yes, specify Cuban, Mexican, Puarto Rican, atc.)					4. Race - American Indian, Bleck, White, etc.  Specify: Black				
ete l	15. Decedant's (Spacify only highast)	Education grada completed)	16	a. Decedant's Us	sual Occupa	ation during most of w	orkina	16b. Kind of B	usinass/Indi	ustry	
du	Elamantary/Secondary (0-12)	Collaga (1-4or	5+)			during most of w					
S	10			Housek	eepe				ekee	ping	
Be	17. Fathar's Nama (First, Middla, La James H. Nel							a, Maidan Suman			
2								e Jones			
	Parthenia Chappe.	LL/Aunt	45	610 Marbel	ass (Street a	and Number or A Rd., Balt	imore, MD	ber, City or Town, 21239	Stete, Zip	Code)	
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	4 Donation 5 Other (Spe		TREUL				1	Balti		/	
once.	Thomas Grego	14 15		Crema 299 F	rede	Socie rick R	ty of l	Marylan timore,	d, I	nc. 21228	
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an	Shook, of flagit failula. List of	ly one cause on each	110.							Onsat and Death	
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er	rasulting in deeth)	a. <u>Obo 1</u>		a consequence of		111.		-			
Je L											
edical Examiner	Sequentially list conditions,	Dua to (or as a	a consequence of	of):			•				
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Ca	that initiated evants rasulting in death) Last	c	Dua to (or as a	a consequança o	of):						
	raduling in Coalin, East	d									
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pleted								s an autopsy formad?	ava	ra autopsy findings ilabla prior to aplation of causa laath?	
Eo							10	Yas 20 No	10	Yas 2□ No	
BeC	25. Was casa rafarred to medical	1				26. Placa of D	eath (Check only				
To B	axaminar? 1 ☐ Yas 2 █ No	Hospital:	ant 2 ER/C	Outpatient 3□	DOA Oth	or.		sidance 6 Ott	nar (Specify	)	
tion: T	27. Menner of Death  1 Netural 5 Pending	28a. Data of Inju (Month, De	ury 28b	. Tima of Injury	28c. Injun Work	y at k?	-	how injury occur		,	
Certification:	2 Accident Investiget 3 Suicide 6 Could no 4 Homicide datermine		M 1 ☐ Yas 2 ☐ No  larm, street, factory, office 28f. Locatic City or			ation (Straat and Number or Rurel Routa Number, or Town, Stete)					
Medical Certification: To Be Com		Physician: To the best									
edicai	one)	aminer: On the basis of and mannar s		andor massigati	ion, in my o	pirilori, daatii oo	Curred at the time				
2	29b. Signature and titla of certifier			1	29c. Licans			29d. Data signe	ed (Month, L	Day, Year)	
	Church fa	as MD			RES	-00C	)	MAY S	1,2000	0	
	30. Nama and addrass of person wh										
18	DAVID ZAAS, MO	,600 NOR	TH WO	FE, BA	LTIM	ORE, M	MARYLAN	D 212	287		
State	31. Data filed (Month, Day, Year)	32. Ragist	rar's Signatura	sports							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

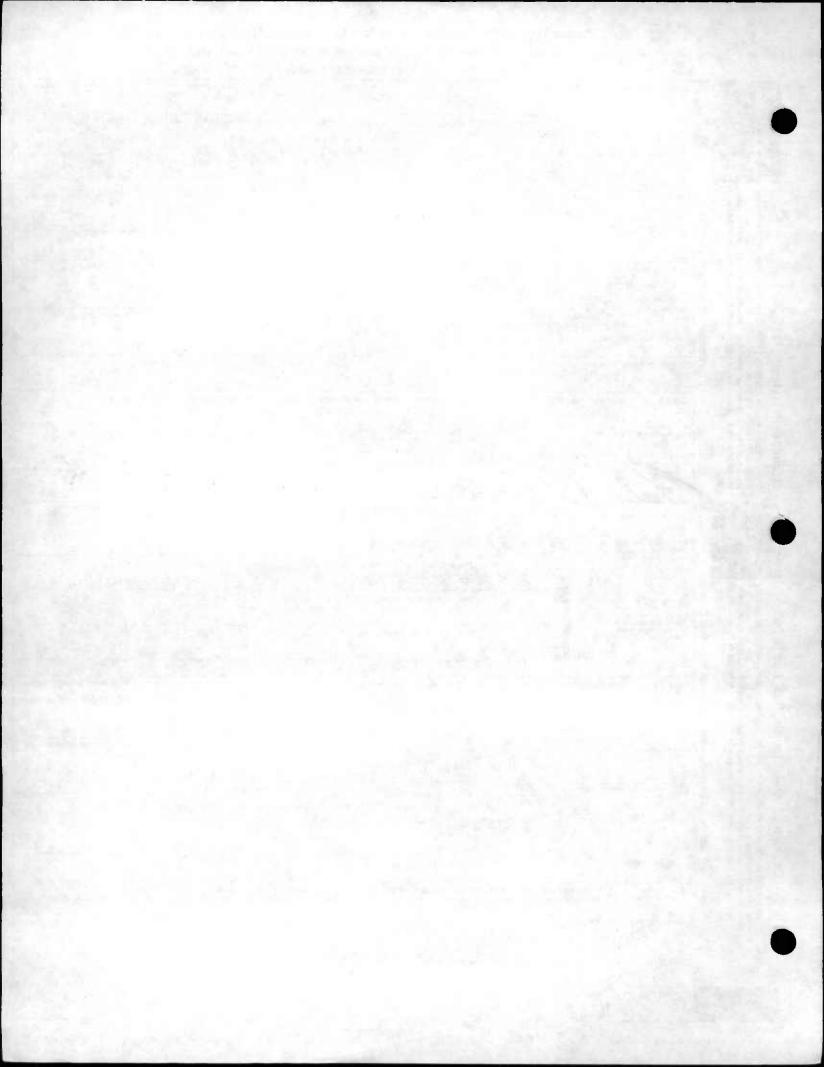
State of Maryland / Department of Health and Mental Hygiene 0 14542

			Certific	ate of	Death			Reg. No.		
1. Decedent's Nama (First, Middle, La ian PEARL ODEN	ist)				ħ.		2. Date of De Month	eth Day 29	Yaar 2000	3. Tima of Death 6:30
4e Facility Neme (If not institution, given MANOR CARE ROLAND E					4b. City, To		ocation of Deeth	4c. Coun	y of Death	RE CITY
	Sax 1□ M 2∏ F 80	a (fn yrs. last bi	Yrs. If U	nder 1 Yaer ths Days		24 Hrs. Min.	8. Data of Bir Month, Da 2-11-19		9. Birth	place (State or Foreign http:// IORE CITY
10a. Stata 10b. County		10c. City, Tow	m or Location	CITY						l0d. Inside City Limits
MARYLAND N/A  10e. Street and Number  1248 PEACHLEAF CT.						10f. Zip Code 21231				ntry?
11. Marital Status  1 Naver Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gri  Elamantary/Secondary (0-12)  6TH	12. Was Decedant Armad Forcas? 1 ☐ Yas 2 ☑ I If Yas, Giva Yaar or Datas:		13. Was Decedent of Hispanic Origin? (Specify Yes or If Yas, specify Cuban, Maxican, Puarto Rican, etc.)  1□ Yas 🌠 No Specify:				ecify Yes or No Rican, etc.)	No- 14. Race - Amarican Indian, Black, Whita, atc.  Specify: BLACK		atc.
15. Decedent's Education (Specify only highest grade completed)  Elamantary/Secondary (0-12) Collega (1-4or 5+)			Sa. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				ing	16b. Kind of Businass/Industry		
6TH  17. Fathar's Nama (First, Middle, Last)			DOMESTIC 18. Mother's Nema (Fi			a (First, Middle	SELF-EMPLOYED (First, Middle, Maiden Sumame)			
BENJAMIN ODEN		RACHEL HENSON								
19a. Informant's Name/Ratationship ( HAZEL* OLIVER/ DAUG		19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1248 PEACHLEAF CT. BALTIMORE, MARYLAND 21231					Code)			
157 Burial O Cometion 2 Demoust from State Cem			of Disposition (Name of ery, crematory or other place) CALVARY CEMETERY 4/3/00				20c. Location - City or Town, Stat DO BROOKLYN, MARYLAND			
21 Signature of Funeral Service Lice		100	170		ass of Facili		ILLIAM C. BALTIMO			Y FUNERAL HO
23a. Part1. Entar tha disease, or coar shock, or haart tailura. List only Immediate Cause (Final diseasa or condition rasulting in death)	Ala	GONAL ASP	TRATION consaquance	ot):		Carolac	or respiretory a	mest,		Approximete interval Betwaen Onsat and Death  2 HOURS
Sequentially list conditions, if any, laeding to immediate causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Lest  Dua to (or as a consequence of):  Dua to (or as a consequence of):  d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of									2 YEARS	
Part II. Other significant conditions of	contributing to death be	ut not resulting l	ng In tha undarlying causa givan in Part I.				23b. Did tobacco use contribute to the caus  1 ☐ Yes 2 ☼ No 3 ☐ Probably 4			
							24a. Was	en eutopsy ormad?	av	ere autopsy findings ailabla prior to impletion of cause daath?
							10		1	☐ Yes 2☐ No
25. Was case referred to medical exeminer?  1 ☐ Yas 2 ▼No	Hospital:	int 2□ ER/O	utpatient 3	DOA O	har:		h <i>(Check only c</i> oma 5 ☐ Rasi		thar (Speci	(y)
27. Manner of Death  1 X Natural 5 Pending 2 Accidant Invastigation 3 Suicida 6 Could not b			8b. Tima of Injury Mork? 28d. Dascribe how injury occurred Work? 1 \[ \text{Yas} \ 2 \sqrt{No} \]							
4 Homicide detarmined		ury - At homa, fo c. (Specify)						Location (Street and Number or Rural Route Number, City or Town, State)		
(Check only 2 Medical Exar	nysician: To the best of miner: On the basis of and mennar ste	axaminetion ar								
29b. Signatura and titla of cartifiar	Phall	0		29c. Licen D1809				29d. Date signed (Month, Day, Year) 3-31-2000		
30. Nama and addrass of person who 1838 GREENE TREE RD.		The second secon		DR. M	ITCHAE	L RU	DIKOFF			
te 31. Data filad (Month, Day, Year) ar MAY 0 4	32. Ragistra	ar's Signatura	4	1						

DHMH 16 Rev 6/95

HALL E SOOK

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death O'NEAL Month Year 8.00 AM **Physician** Raymond -2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Howard County General Hospital Columbia Howard Hours Min. 8. Date of Birth (Month, Dey, Yeer) Sept. 21, 1944 North Carolina If Under 1 Yeer 7. Age (In yrs. last birthdey) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Deys Yrs. 243-68-9881 55 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 XNo Directo Maryland Howard Ellicott City 28a-f must be notifi-10e Street and Number 10f. Zin Code 10g. Citizen of What Country? tems 23a or 7819 Old Hollow Ln. 21043 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritel Status 1½ Yes 2 No If Yes, Give Yeer or Detes:1967-69 1 Never Married 25 Merried ö Specify: white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced permit. Pages 1 and 2 should be fised within 72 hous Department of Health and Mental Hygiene. Important: if Item 27 is marked other in any injury or other traumers other. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Demolition Expert Self-Employed 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Lest) Unknown Helen Hicks 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Joselle O'Neal / spouse 7819 Old Hollow Ln. Ellicott City, MD. 21043 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete May 9 tXXBuriel 2 ☐ Cremetion 3 ☐ Removel from State Garrison Forest Garrison, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical METASTATIC SQUAMOUS CELL CARCINOMA

Due to (or es e consequence of): & left lung. one Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) 950 Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? LARYNGEAL CARGNOMA. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Be Completed Hypersensian hes HYPOTHY ROTOLS A page 1 ☐ Yes 2 No 1 🗆 Yes 2 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Death 28e. Date of fnjury (Month, Dey Year) 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier To the Hosp within 24 hou To the Funer completely fil edical (Check only one) 29b. Signeture end title of certifing

Registrar **DHMH 16 Rev 6/95** 

The lew requires that the death certificate be executed

Physician:

Hospital

-B.16

31. Dete filed (Month, Dey, Year)

MAY 0 5 2000

30. Name and address of parson who completed cause of death (Item 23e) (Typa, Print) 9055 CHEVROCET PRINE: \$100

Box 68760,

P.0.

of Vital Records,

Division or Attending

hours after

altimore, Maryland 21215-0020

**ORIGINAL** 

N. B. VELLANKI

32. Registrer's Signeture

29d. Date signed (Month, Dey, Year)

29c. License number 1.30469

2000

ElliceTT CTT. MD. 21042

See to hear

1700 - 9 7 - 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 1, 5 1, 1

			Certificate of	Death	Re	g. No.	14044		
Dharaisian	1. Decedant's Nama (First, Middle, I	ast)			2. Data of Death Month	1	3. Tima of Death		
Physician /Medical	Albert H. Podw	e11			May		2000 9:45 A.M.		
Examiner	4a Facility Nama (If not institution, g			4b. City, Town, or Lo	cation of Death	4c. County of	Death		
NA T	Harford Memoria	•		Havre De		Harfo			
Funeral Director	372-09-7196	5ex 15 M 2□ F 7. Age (In yrs. Ia 94	Yrs. If Under 1 Yaa Months Days		8. Data of Birth (Month, Day, 10/01/1	Year) 905	Birthplaca (State or Foraign Country) Ohio		
Du Ras	Usual Rasidence of Decedant 10a. Stata 10b. County	10c. City.	, Town or Location				10d. Insida City Limits		
with the Marylar a or 28s-f show Libe notified at Director	MD. Cecil	Pe	erryville			1 ☐ Yas 2 MNo			
er death with the Marys flems 23e or 28e-f sho ner must be notified at uneral Director	724 Broad St.		10f. Zip Code 219			10g. Citizan of What Country? USA			
O20 urr alt	11. Marital Status  1   Nevar Married 2   Married 3   Widowed 4   Divorced	6. 13. Was Decedent of If Yas, specify Cu	Hispanic Origin? (Spe ban, Maxican, Puarto o Specify:	ecify Yas or No- Rican, atc.)	No- 14. Race - American Indian, Black, Whita, atc.  Specify: White				
l 21215-0 ed within 72 ho ygiere. er then 'netur t, the Medical. Completed	15. Decedent's (Specify only highest of		16a. Decedent's Usual Occu (Give kind of work done	e durina most of worki	ng 1	6b. Kind of Busin	eass/Industry		
2121 d within giene. r then the Me	Elamantary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed)					
Co n. th	17. Fathar's Nama (First, Middle, La:	and the second s	Clerk	18. Mothar's Nama		Painting Company			
and the file	Albert H. Podwe		The second secon	M. McCi					
should be and Mental marked urmaft e	19a. Informant's Name/Ralationship	(Type Print)	19b. Mailing Address (Stree						
Mand 2	The second of	Nephew	1111 Fawn Gr						
Ore, as 1 as	20a. Mathod of Disposition	20b. Pla	ace of Disposition (Name of metery, crematory or other pl	ace)		Oc. Location - Cit			
Pag Pag martin	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Balt	22. Nama and Addi	natory	05/05 La	aure1, M	D.		
Balti permit. Departments imports any inju	21. Signatura di Punarai Sarvice de	Dlarke	Bradley A	ashton Matt ow Spring					
	23a. Part1. Entar tha disease, or co shock, or heart failure. List on	mplications that caused the death.	. Do not enter the mode of dy	ring, such as cardiac o	or respiratory arre	st,	Approximata Intarval Batween		
Physician									
/Medical Examiner	Immediata Causa (Final diseasa or condition rasulting in death)	a day	te mysoc	wena	mya	nous			
·	, and a state of the state of t	Due to (or	as a consequence of):		V				
executed n and sel-transit		b							
58760, icate be executed physicien and s the burial-transit	Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Disease or injury	Due to (or	as a consequence of):						
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N Paris	resulting in death) Last	I d							
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.O. the dy the cheed	Part II. Other eignificant conditions	contributing to death but not resul	ting in the underlying causa g	iven in Part I.		bute to the cause of death?			
S, P as that igned b be date by Pt	pounding	roune			10 10	s 2□No 3	Probably Duknown		
ord requir neen s hould	Dementia				24a. Was an perform		24b. Wara autopsy findings available prior to complation of causa of death?		
The law ate hes b page 2 s	Phlundri	25			1□ Ya:	s 2000	1 ☐ Yas 2 ☐ No		
Vital I siclen: The certificate irrector, page o Be Co	25. Was casa rafarred to medical			26. Place of Death		0	7 1 1 1 2 2 1 1 1 0		
Of Vita Physician: this certific rel director.	axaminar? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 E	R/Outpatient 3□ DOA O	ther	ma 5 ☐ Rasider		(Specify)		
g Physical disparation of True disparation of	27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of 28c. Injury		28d. Dascribe ho				
Vision Attending or deeth. ector: After by the fune	1 SNatural 5 Panding invastigati	on		Yas 2 No					
Division of the or attending P as a for each.  al Director: After tied in by the funer ied in by the funer Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide detarmine		na, farm, street, factory, office	9 2	28f. Location (Str. City or Town,		or Rural Route Number,		
C signature C									
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (	29a. Certifier (Check only one)  Certifying F  2 Medical Exp	thysician: To the best of my know imfiner: On the basis of examination and manner stated.	ledge, death occurred at the on and/or investigation, in my	tima, data and place, a opinion, daath occurre	and dua to tha ca ed at tha tima, da	usa(s) and mann ta and place, and	ar as stated. I dua to tha cause(s)		
To the within To the To the comp	29b. Signature and title of certifiar		29c. Licer	nse number	29	d. Date signed (	Month, Day, Year)		
	Have so	in Um	t	3736C	t, /	May 5	12000		
()	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	1000	1	0			
7	19 Walke	i hull, Als	ender 1	wycu	4				
State Registrar	31. Data filed (Month, Day, Year) MAY 05	32. Registrar's Signatu	15 Apa	Ka .					

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TO SEE SEE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Sophie Ianthe Puepke 29, April 2000 1:35 PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ridgeway Manor Nursing Home Catonsville Baltimore 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 97 Yrs. 1 M AEJE 215-32-8473 Director Feb. 24, 1903 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show than "natural", or items 23s or 28s-f show the Medical Exercines must be notified at 1 ☐ Yes ANO Director Maryland Catonsville Baltimore 10e. Street and Number 5743 Edmondson Avee. Ridgeway Manor Nursing Home 10f. Zio Code 10g. Citizen of Whet Country? 'natural', or items 23a 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 又 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Black, White, etc. 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ XX ⊠ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Storekeeper Own Business is marked other permit. Peges 1 end 2 should be file Deportment of Health and Mental Hy Important: If flem 27 is marked other any Injury or other traumatic event price. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Todd Carrie Veditz 19a. Informent's Name/Relationship (Type, Print) (Nephew) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Morgan Avenue Norwalk, CT Mr. Robert Tod Bryant 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1X Surial 2 Cremetion 3 Removal from State Woodlawn Cemetery 5/3/00 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn, 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Burgee-Henss-Seitz Funeral Home, In 3631 Falls Road Baltimore, MD 21211 3631 Falls Road Baltimo.

For complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause or each line. Part . Enter the disease, shock, or heart tailure L **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner that the death certificete be axecuted attending physician end for use es the buriai-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Dete of tnjury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after deeth. 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc complately filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name end eddress of

31. Dete filed (Month, Day, Year)

MAY 05

DHMH 16 Rev 6/95

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 4546 State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Deeth Physician obert 4:00 OL 26 200D /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of 4c. County of Deeth Examiner 6. Sex If Under 24 Hrs. 8. Date lari Baltimore Imonium 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 100M 20 F Months Days Hours 217-90-890 2 Usuel Residence of Decedent Yrs. Director 12 02 Maryland 1962 10a. State 10b. County ahow 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahov the Madical Examinar must be notified at 1 ☐¥es 2 ☐ No Director altimore 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2202 1216 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race · American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Itama 11. Meritat Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No JITICIAN p.m. 1 Yes 2 No Specify: If Yes, Give Year or Dates: Š 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Hyglene. Merchandizing Stores 1 and 2 should be flied w Health end Mentel Hygler om 27 la marked other th Stodia Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be V. Kav arler nariotto permit. Pagas 1 and 2 sh Department of Health end Important: if Item 27 is m any injury or other traum once. 19a. Informent's Name/Relationship (Type, Print) Mother 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220. more, Md. 21216 Baitimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriat 2 ☐ Cremetion 3 ☐ Removal from State Baltimore. Greenmount 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Modress of Facility UOSEPH L. RUS 2222W.north Ac uss 23a/Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. ACQUIRED IMMUNE DEFICIENCY SYNDROME Examiner Due to (or es a consequence of) Examiner physician and s the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown à Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No Vitai al or Attanding Physician: T s after death. I Diractor: After this certificat ed in by the funaral director, p Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury el Work? 28d. Describe how injury occurred 1 Naturet 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide e Hospital or A 24 hours after a Funeral Dira sletely filled in b 1K) Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

26,

ROBERT

32. Registrar's Signature

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

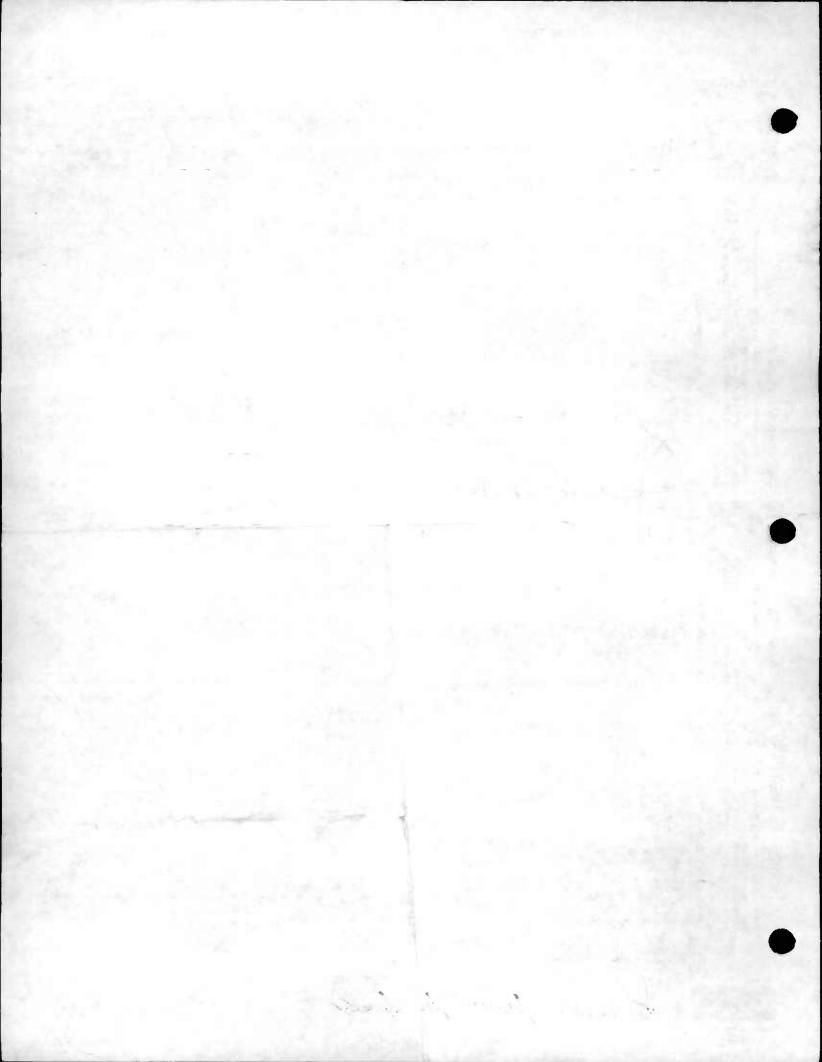
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nysician	1. Decedent'e Neme (First, Middle, Las	e)	Cer	tificate of	Death	2. Dete of Deet	g. No.	3. Time of Death	h
Medical	Ka	thryn Mary	Rueh1			May 3	2000 Yee	3:00PI	
aminer	4a Facility Neme (If not institution, give Charlestown C				4b. City, Town, or Lo		4c. County of De Balt	imore	
eral ctor	5. Social Security Number 6. Se		yrs. last birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, OCT 10,	Year) 9. E	irthplece (State or Fore Country) nnessee	ign
	Usuel Residence of Decedent  10a. Stete 10b. County	100	. City, Town or Lo	pation				10d. Inside City Lim	nits
ctor	MD Baltimo	re	Catonsv	ille				1 □ Yes 🗶	No
al Director	10e. Street and Number 709 Maiden Cho:	ice Ln., #	407	10f. Zip Code 21 2	228	U	10g. Citizen of Whet Country?		
by Funeral	11. Meritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1  Yes 2 No If Yes, Give Yeer or Detes:	11	,S. 13. Was Decedent of Hispenic Origin? (Sp. It Yes, specify Cuben, Mexican, Puerlo			Specify Yes or No- no Rican, etc.)  14. Raca - American Indien, Black, White, etc.  Specify: White		
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Be	17. Fether's Neme (First, Middle, Last)		50	PELVISO	18. Mother's Name	(First, Middle, N	faiden Sumeme)	Haryran	u
To	Thomas C. Back		19b. Meilin	g Address (Street	end Number or Run	Litzii		, Zip Code)	
	Arlene K. Gill/			-	Ct., Ca				7
	20e. Method of Disposition  1 Duriel Tornetion 3 D  4 Donetion 5 Other (Specify	Domoval from State		etory or other ple			Baltimor		
	Idens A.	roy or all	خ ا 2 2	Name and Addre remation	ss of Facility on Socie	ty of M	laryland imore,	, Inc.	
dical Examiner	4 Donetion 5 Other (Specify)  Metro Crematory, Inc. 5/4/00  Baltimore,  2. Name and Address of Facility  Cremation Society of Maryland,	b	to (or es e conseq	uenca of):	740(4)			7	
Me	resulting in death) Lest	4							Limits Ind  Ind  Ind  Ind  Ind  Ind  Ind  Ind
clan/Me		d				one bld to	hanna ann ann an an an an an an an an an		AL 0
Physician/Me	Pert II. Other significant conditions or	d	resulting in the ur	derlying cause give	ven in Pert I.			nte to the cause of dea	
by Physician/Me		d	resulting in the ur	derlying cause giv	ven in Pert I.		n autopsy 24	D. Were eutopsy finding eveilable prior to completion of cause	own
by Physician/Me		d	resulting in the ur	derlying cause giv	ven in Pert I.	1 ☐ Ye	n autopsy ned?	Probably Unknow.  D. Were eutopsy finding eveilable prior to	own
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ORIGINAL

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND I	State of Maryland / Department of Health and FEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death  1. Decedent's Name (First, Middle, Last)		leg. No.	3. Time of Death					
Physician /Medical	Alexander Robertson, Jr	Month April	30, 2000	1218 pm					
Examiner	46 Fecility Nama (If not institution, give street and number)  45. City, Town, o  3711 Chatham Road  Baltime	r Location of Death	4c. County of N/A						
Funeral Director	5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hr 219-02-5972 17 M 2 F 32 Yrs. Months Days Hours Min	S. 8. Data of Birth		9. Birthplece (Steta or Foreign Country) Md					
show	Usual Rasidance of Dacedent  10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits					
28a-f shonouthed at	Md . N/A Baltimore		W	1 Vas 2 □ No					
inet must be or 28a-fai inet must be nothed Funeral Director	10e. Street end Number 10f. Zip Code 21215	1.	10g. Citizan of What Country? USA						
o A	11. Marital Status  1 Navar Married 2 Married  3 Widowed 4 Divorced  12. Was Decadant Evar in U,S. Armed Forces?  1 Yes, Specify Cuban, Maxicen, Pus 1 Yes, Specify Cuban, Maxicen, Pus 2 No If Yes, Siva Year or Datas:	(Specify Yas or No- arto Rican, etc.)	Black,	- Americen Indian, Whita, atc. Black					
To Be Completed	15. Decedant's Education (Specify only highast grada complated)  Elamantary/Secondary (0-12) 12th grade  16a. Decedant's Usual Occupation (Giva kind of work dona during most of w lifa. DO NOT use retired)  Laborer	orking	16b. Kind of Busi Home Im	provement Co.					
Be Co		ama (First, Middle,	Maidan Sumama	)					
ToB	Alexander Robertson, Sr Evelyn	Moore							
ဥ	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Street and Number or I								
	20a. Majurd of Disposition 20b. Place of Disposition (Name of	Baltimore		∠15 lity or Town, Slata					
	Thirial 2 Crametion 3 Ramoval from State Command Communication Science Repeated From State King Memorial Park	5-6-00	Randall	stown, Md					
- Buce	22. Nama and Address of Fecility  March F/H West  4300 Wabash Avenu  23a Party Enter the disaasa, or complications that causad tha death. Do not anter tha mode of dying, such as cardinate. Itst only one cause on each line.	ie Balt	imore, M	d 21215 Approximate					
dical	Immediate Cause (Final disease or condition resulting in death)  a. NARCOTIC INTOXICATION Due to (or as a consequence of):  Sequentially list conditions.	- 7							
edical	Causa (Disaasa or injury that initiated avants rasulting in death) Last  Dua to (or as a consequenca of):								
Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did t	23b. Did tobacco uea contribute to the cause of						
by Physic	COCAINE USE	_ 1□`	rss 2□ No	3 ☐ Probably 4 ☑ Unknow					
Completed t		24a. Was perfo	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death					
S		100	res 2 No	1 Dives 2 No					
Be	examiner? Hospital: Other:	eath (Chack only o							
funeral dire	27. Manner of Death 28a. Dete of Injury 28b. Time of D 28c. Injury at	Homa 5X Rasio	now injury occurre						
catio	2 Accidant investigation 4-30-00 12:00	UNKNOV							
Certification:	3 ☐ Suicida 6 ☑ Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) FOUND AT HOME	ffice 28f. Location (Streat and Number or Rural City or Town, State) 3 / 11 CHA BALTO. CITY, MD.							
Medical Certifi	29a. Cartifiar  (Check only one)  Contifying Physicien: To the best of my knowledga, daath occurred at tha tima, data and ple (Check only one)  Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and ple (Check only one)	ce, and dua to tha curred at the tima,	causa(s) and man data and place, ar	nar as stated. nd due to tha causa(s)					
×	29b. Signature and titla of certifier  O.C.M.E.			(Month, Day, Year) 2000					
State	30. Nama end and less of person who completed cluse of death (Item 23a) (Type, Print)  SER (FESTAME 1.11 Penn Street, Bal:  31. Dete filed (Month, Day, Year)  32. Ragistrar's Signature	timore, M	aryland	21201					
Registrar	MAY 0 5 2000 perme D. Lookely								



**DHMH 16 Rev 6/95** 

State

Registrar

s. Raguroy, 31. Date filed (Month, Day, Year)

MAY 0.5 2000

32. Registrar's Signature

MD 21047

MAY 0 5 2001 Secure

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time ol Death Month **Physician** ANDREW STEWART 02,2000 May 5:30PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAMILTON CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1√ M 2□ F Yrs. 241-48-3131 Director 66 MAR. 13, 1934 NORTHCAROLINA Usual Residence of Decedent 10a State permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mentel Hyglene.
Important: if item 27 is marked other than "natural", or itema 23a or 28a-f ahow with fultry or other treumatic event, the Madical Examiner must be notified at page. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1426 E. LANVALE STREET 21213 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas X□ No Specify: ABBO-AMERICAN \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) VON PARIS MOVING CO. 10TH TRUCK DRIVER 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be ANDREW STEWART, SR. MARY HODGES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) HELEN M.STEWART/ WIFE 20b. Place of Disposition (Name of cametery, crematory or other place)

1426 F. LANVALE ST. BALTO, MD. 21213

20c. Location - City or Town, Stata 20a. Mathod ol Disposition 1 Burial 2 Cremation 3 Removal Irom Stata KING MEMORIAL PARK MAY 8,2000 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediata Causa (Final disease or condition rasulting in death) /Medical Stope Myofe Examiner Dua to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, lan/Medical Dua to (or as a consequence of) Physici been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Ware autopsy lindings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? has certificate 1 Tas 1 ☐ Yas 2 ☐ No Mospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this cartification of the funeral director, Be 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1□ Yas 2☑ No Other: Nursing Home 5 Residence 6 Othar (Specify) edical Certification: To 28a. Data ol Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) in Chillip Olisis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and Mile of certifie 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) D105 21237 Mama ton MM 31. Date liled (Month, Pax.) 32. Registrar's Signatura State 5 2000

**ORIGINAL** 

Registrar

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Physician	an		MS: #23 PART I, 11 F. 247 PER MEO Certificate of Dea 1. Decedent's Name (First, Middle, Last)  Barton M. Spencer				Date of Dea Month MAY 2	th Day	Year	3. Time of Death 2200 PM			
/Medi Exami	_		(If not institution		e street and number) 4b. C				4b. City, Town, or Location of Death COCKEYSVILLE				
Funeral Director		5. Social Security 103-36-3	Social Security Number    03-36-3096				t birthday) If Under 1 Year If Under 24 Hrs. 8. Data (Months Days Hours Min. (Months Min. )			Data of Birth (Month, Dey			ace (State or Foraig y) Jersey
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State of Maryland / Department of Health and Mental Hygiene 1 4552

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Physician	1. Decedent's Name (First, Middle, Las	()			2. Dete of Deer Month		3. Time of Death	
/Medical	Esther Lill	ian Stabnau	1		May 2		5:00 PM	
Examiner	4e Fecility Name (If not institution, give	street and number)			or Location of Deeth	4c. County of E	Deeth	
	Heart Homes			Odento		Anne	Arundel	
Enucari Director	5. Social Security Number 6. Security 176-16-9717	7. Age (In yrs. 78	Yrs. Months			1921 Pe	Birthplece (State or Fore Country) ennsylvani	
	10a. State 10b. County	10c. Cit	ty, Town or Location				10d. Inside City Lim	
	MD Anne Ar	undel 0	lenton				1 □ Yes 2 □ I	
	10e. Street end Number 8735 Piney Orch	nard Parkway		ip Code 21113	1	0g. Citizen of Whe	t Country?	
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Merithin Merithin	29b. Signature and title of certifier		2	9c. License number	2	9d. Date signed (A	Month, Day, Year)	
	Mash	als		051810	1	Wand	3,2000	
	30. Name and address of person who of	ompleted cause of deeth (Iter	n 23a) (Type, Print) /833	A. FUL	est or	ive, A	3, 2000	
State	Date filed (Month Day, Year)	32. Registrer's Signa	eture /					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 4:29 PM ANNA SMITH MAY 2000 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Medical Johns Hopkins Bayview If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foraign Country) 6. Sex Hours Months 1 M 2 KF 212m10m4619 93 10/05/1906 MD. Usual Rasidence of Decedant 10c. City, Town or Location 10d. Insida City Limits 10b. County Baltimore Dundalk 1 Yas 2 No Md. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? **IISA** 21222 3004 Dunmore Rd. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 MNo Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elamantany/Secondary (0-12) Collega (1-4or 5+) Seamstress Clothing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Paul Gawel Anna Marek 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19e. Intermant's Name/Raletionship (Type, Print) Alice G Chenkovich Daughter 3290 Clifford Circle Pleasanton, CA. 94588 20b. Plece of Disposition (Nama of camatery, crematory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition 1 ■Burlal 2 □ Cramation 3 □ Removal from Stata Oak Lawn Cemetery 05/04 Baltimore, MD. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service Lic 22. Nama and Addrass of Facility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Rd. Baltimore, MD. 21222 Approximata tntarval Batween Onsat and Daath 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. Lift only one cause on each line. Immediata Cause (Finel diseasa or condition rasulting in death) bro vascular Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of) Due to (or as a consaquance of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 ☐ Yas 2 No 26. Placa of Death (Check only ona) Hospital:

**Physician** /Medical Examiner physiclen end s the burial-transit the death certificate be executed Box 68760 for use as ed by the a Division of Vital Records, P.O.

Examiner Physician/Medical been signed by should be detec à Completed has director, Be 2 this funeral Certification: epital or Attending hours efter death. neral Director: Afti y filled in by the fun Hospital 24 hours

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**Physician** 

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Funeral

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**Funeral** 

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item 27 is marked other than "natural", or items 23s or 23s-f show other traumatic event, the Madical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mentel Hygiene. Important: if frem 27 is marked other than "natural", or her any injury or other treumatic event, the Medical Exercise page.

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| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian (Check only one)

State Registrar

31. Data filed (Month, Day, Year)

29b. Signature and titla of certifier

MAY 0 5 2000

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print) 4940 Eastern Ave., But more

32. Registrar's Signatura

Ave. Butimore

29c. Licanse number

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29d. Data signad (Month, Day, Year)

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State Registrar

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31. Dete filed (Month, Dey, Year)

Stephen

Radentz
32. Pogistrar Signature

9. Sports

111 Penn Street, Baltimore, Maryland 21201

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month THOMPSON DANIEL **Physician** 0300 May 00 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner DEATON SPECIALITY HOSPITAL AND HOME INC BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months XXM 2 F Director 38 April 24 1962 MARYLAND 220-80-1539 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryls 7 is marked other than "natural", or items 22a or 28a-f short traumatic event, the Medical Examinar must be notified at MYes 2 □ No Directo MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number U.S.A. Funeral 5461 CEDONIA AVE Apt 1A 21206 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Meritel Status Black, White, etc. 1 ☐ Yes 2€XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ※ Married Hompson, Lan 1 Yes XXNo Specify: ğ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) CARPENTRY 12th grade CARPENTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mental DONALD M THOMPSON 2 REGINA SMALLS Pages 1 and 2 should 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Department of Health a Important: If them 27 is any injury or other tra Regina Cooke/Mother 7203 Brook Crest Way, Baltimore, Maryland 21208 20c. Location - City or Town, Stete 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) Dete 20e. Method of Disposition 1 X Suriai 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MT ZION CEMETERY 5-9-00 BALTIMORE, MARYLAND 22. Name and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE art1. Enter the disease, or conshock, or heart failure. List only tions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset end Death **Physician** End Stage Renal Disease /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner wedminumo physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequenca of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) for use es signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Hepatitio B = C þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en autopsy Completed After this certificete has funeral director, pege 2 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending Injury death. 1 Yes 2 No investigation ector: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) An 24 hour.
The Funeral Directory.
The filled in by 4 ☐ Homicide 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edicai (Check only 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number Carla S. Celeyander MD 5/4/2000 D27087 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CARLA S. ALEXANDER, MD 29 S. greene St Suite 300 Baltimore Md

21201

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

MAY 0 5 2000

32. Registrar's Signeture

MOZSERON A JOHNSON 3683 AN 4 PAIN الناول المادين القاسم الأساعين La la let aud l'amongée made of the second of the second of the second AND PRODUCED TO THE SECRETARY OF THE PRODUCED AS A SHARE MAY 08 2790 Some of spreads

Please Type or Print in Biack indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent'a Name (First, Middle, Last) Day Month 2:45 AM 2000 May 1, Dianne A. Tecklenberg 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20 Vista View Court Kingsville Baltimore Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1 M 2 F Months 578-60-3382 57 Dec. 22, Wash. D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Baltimore Kingsville 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 20 Vista View Court 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married white 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) home 12 yrs. housewife. 5 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel J. Anderson Alice Klopstad 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Dr. Paul L. Tecklenberg (husband) 20 Vista View Court Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fallston Highview Memorial Gardens 5/6/2000 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.F.Lassahn Funeral Home assahr 11750 Belair Rd. Kingsville, MD 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

**Examiner** 

Funeral

Director

Show

r than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after of Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or han any injury or other traumatic event, the Medical Exempt

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Completed by Funeral Director

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death

Examine To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be data-had for many the funeral director, page 2. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical

þ

Be Completed

edical Certification: To

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of) Due to (or as a consequence of):

Part II. Other afgnificant	t conditions con	tributing to death but not res	sulting In the underlyin	g caus	se given in Pert I.	23b. Did tobacco use co 1 ☐ Yes 2 ☑ No	ontribute to the cause of death?  3 Probably 4 Unknown
						24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
25. Wes case referred to	medicel				26. Plece of De	eath (Check only one)	
examiner? 1 Yes 2 No	F	lospital:	ER/Outpatient 3	DOA	Other: 4 Nursing	Home 5. Residence 6 □Ott	her (Specify)
27. Menner of Death  1 Matural 5  2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of Injury - Al h building, etc. (Speci	ome, farm, street, fac	tory, o	ffice	28f. Location (Street and Num. City or Town, Stete)	ber or Rurel Route Number,

State Registrar

31. Date filed (Month, Dey, Year)

MAY 0 5 2000

THANT

29b. Signature and title of certifier

MYO

32. Registrer's Signature

6830 HOSPITAL DRIVE

**DHMH 16 Rev 6/95** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

years

29d. Date signed (Month, Day, Year)

BALTIMURE,

D18487

29c. License number

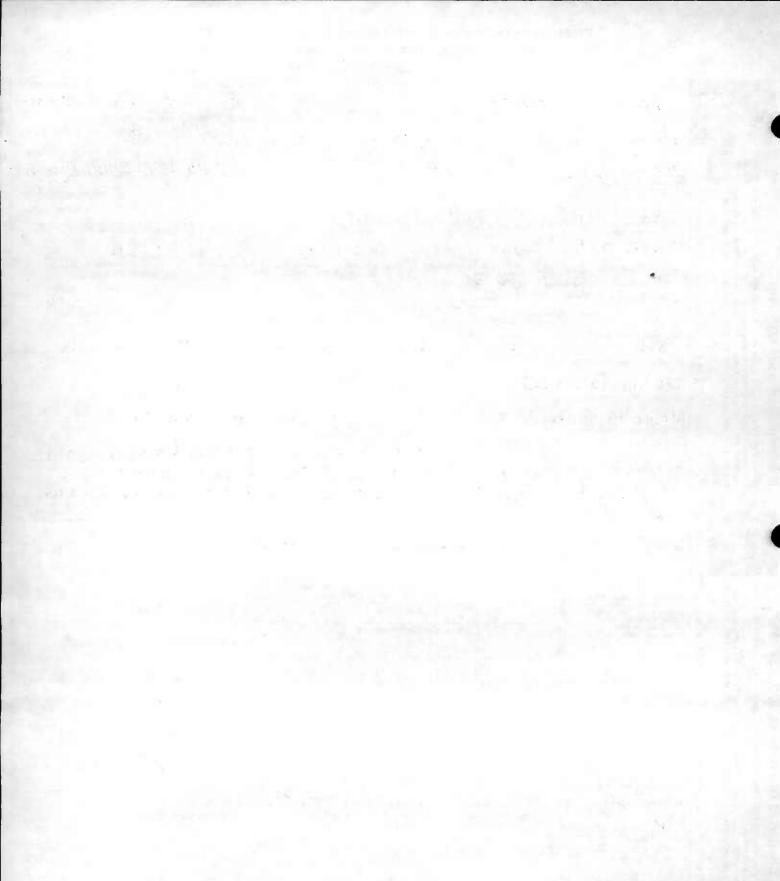
MAY 0.5 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4558 Certificate of Death Reg. No. 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Physician 9:45 AM 2000 FLOSSIE WHITE MAY 3 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner NIa N hday) If Under 1 Year Bal ursing arford sarden -1 More If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 25 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1□ M 20 F 8 South Carolina 250-32-123: Usual Residence of Decedent Yrs. **Director** with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits pamit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mantal Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Kal Director N TIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ave 21218 ISA Funeral alor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Baca - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 PNo Specify: African Saltimore, Maryland 21215-0020 If Yes, Give Year or Detes: Specify þ 3 Widowed 4 □ Divorcad American Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 3rd Domestic Worker Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Buffert Mary Buffert Ohn 19b. Mailing Address (Street and Number or Roral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mrs Ella Voung 711 Cator Ave, Baltimore md. 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Zion 4 ☐ Donation 5 ☐ Other (Specify) 5-9-200n hansdowne, Md em. 22. Name and Address of Facility of Funeral Service Licenses funeral Home 22 22 w.north 21216 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical fmmediate Cause (Final Cerebrovasonlar disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequenca of): ettending physician and for use es the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) signed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy peeu performed' page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificete or Attending Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aftar Injury 1 Naturel 5 Pending investigation daath. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours efter daatle Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. Medicai complately 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of cartifier auctoriated 3 2000 MO D16619 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 0 BALTIMORE MD. 21214 C. VERGARA-SOARES RD 4700 HARFORD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 0 5 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth Dev **Physician** 2 Dreena 4b. City, Town, or Location of Death 2000  $\infty$ /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner JIMORE NA TOSPITAL DALTIMORE If Under 1 Year 5. Social Security Number Birthplece (State or Foreign
 Country) Sex 1□ M 2 F 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys 218-82-4503 Usuel Residence of Decedent Yrs. Director Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No Director d 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 12 SA 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Detes: 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cashier Supervisor Kite 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 and 2 should be ealth and Mental toward Known ASI 19a. Informant's Name/Relationship (Type, Print) / SISTER 19b. Meiling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) of Health a liters 27 is other tre Baltimore, Md 21234 eanwood Baltimore. permit. Pages 1 as Department of Hear Important: If Item: any lejury or othe price. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 D Burial 2 □ Cremetion 3 □ Removel from Stete 5-5-200 Baltimore, Md 4 ☐ Donetion 5 ☐ Other (Specify) 2. Signature of Funeral Service Licente Md.21216 23a part 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical >FP SIS days Examiner Due to (or es e consequence of): DEARCTI OU Physician/Medical Examiner Ola attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed by Records, Leukemia 24b. Were eutopsy findings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 2 No 20 No of Vital or Attending Physician: 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA this Manner of De n 24 hours after death.

Ne Funeral Director: After the pletely filled in by the funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending 1 □ Yes 2 □ No 2 ☐ Accident investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical completely (Check only one) To the I within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar QHMH 16 Rev 6/95

ORIGINAL

the same of the same of

9617 S 7 XV

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Neme (First, Mic JAMES I			Ce	runcate or	Death		Reg. No.	17000
OHILD	die, Last) R. WINS'	TEAD				2. Dete of De Month MAY 3	Dey	Year 3. Time of Death 3:30PM
4e Facility Neme (If not institut	ion, give street end r	umber)			4b. City, Town, or	Location of Deat	-	
JOHNS HOPE	INS HOS				BALTIM		N/A	
5. Social Security Number 230-34-6540	6. Sex	7. Age (fn yrs		Months Deys			y, Year) 5-29	Birthplece (State or Foreign Country)     WEST VIRGINI
Usuel Residence of Decedent  10a, Stata  10b. Coun	hv	10c C	ity, Town or Lo	ocation	<del></del>			10d. Inside City Limits
	./A			ALTIMOR				1 ☐ Yes 2 ☐ No
10e. Street and Number	I/ A		DF	10f. Zip Code	L		10g. Citizen of V	Λ
	FAYETTE	AVE.			1213		U.S	
11. Merital Status  1 Nevar Married 2 M 3 Widowed 4 Divorce	Armed			Was Decedent of If Yes, specify Cul	ban, Mexican, Pue	Specify Yas or No rto Rican, etc.)	Blac	e - American Indian, sk, White, etc. O-AMERICAN
	nt's Educetion			dent's Usuel Occu		a deia a	16b. Kind of Bu	usiness/Industry
(Specify only high Elementery/Secondery (0-12	est grade complete	d) (1-4or 5+)	life.	kind of work done DO NOT use retin	ed) ed)	urking		
8TH			LABO	DRER				HEM STEEL CO
17. Fathar's Nema (First, Middl	. 1112.					ama (First, Middle,		10)
ROOSEVELT	WINSTEA	D			ANNI		WRIGHT	
19e. Informant's Name/Reletio		,		ing Address (Stree				
DAISY A. WI	NSTEAD	/ WIFE		B E. LA	AYETTE	AVE.	BALTO,	MD. 21213 City or Town, Stete
20e. Method of Disposition 1 ☐ Burial 2 ☐ Cramatio	3 Removal from	m State	cemetery, cre	metory or other pl		1		
4 □ Donation 5 □ Other	(Specify)	MT						RA, NORTHCARC
21. Signature of Funeral Service	e License	1.	2	2. Name end Addr CALVIN 1	ess of Fecility B. SCRU	GGS FUN	ERAL H	OME LINA
Dernad	ne //1	orug	90 ]	1412 E.	PRESTO	N STREE	T BALT	
23a. Pert1. Enter the diseese, shock, or heert failure. L	or complications tha st only one cause or	t caused the dee	th. Do not en	ter the mode of dy	ring, such es cerdi	ac or respiratory e	rrest,	Approximate Intervel Between
								Onset and Death
Immediete Ceuse (Finel disaase or condition resulting in death)	θ	Met	astati	ic Lun	g Can	car		2 mo
recording an death)		Due to	or es e conse	quence of):	J			
	b							1
Sequentielly list conditions, if eny, laading to immadiate		Due to (	or es e conse	quence of):				
Sequentially list conditions, if eny, leading to immediate ceusa. Enter Underlying Ceuse (Disease or Injury that injurated events	с		1.56					
Sequentielly list conditions, if eny, laading to immadiate ceusa. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last	с		or es e conse					
that initiated events	c		1.56					
Ceuse (Disesse of Injury that initiated events resulting in death) Last	d.	Due to (	or es e conse	quence of):	ikon in Don't	22h Did	tobacco use co	obtibute to the cause of death
that initiated events	c	Due to (	or es e conse	quence of):	iven in Part I.			ntributa to the causa of death
Ceuse (Disease of Injury that initiated events resulting in death) Last	dtions contributing to	Due to (	or es e conse	quence of):	iven in Part I.		tobacco usa cor Yes 2□ No	ntributa to the causa of death
Ceuse (Disease or injury that initiated events resulting in death) Last	ctions contributing to	Due to (	or es e conse	quence of):	iven in Part I.	1 🗹	Yes 2□ No an autopsy	
Ceuse (Disease or injury that initiated events resulting in death) Last	ctions contributing to	Due to (	or es e conse	quence of):	iven in Part I.	1 🗹	Yes 2□ No	3 Probably 4 Unknow
Ceuse (Diseese or injury that initiated events resulting in death) Last	dtions contributing to	Due to (	or es e conse	quence of):	iven in Part I.	1 🗹	Yes 2□ No an autopsy ormed?	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse
Ceuse (Disease or injury that initiated events resulting in death) Last  Pert II. Other significant condi		Due to (	or es e conse	quence of):		24a. Was perfo	an autopsy med? Yas 2 ₩No	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
Pert II. Other significant condi	cal Hospital	Due to (	or es e consecutive sulting in the u	quence of): underlying ceuse g	26. Plece of D	24a. Was perfe	an autopsy med?  Yas 2 ⊮ No	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?  1 Yas 2 No
Pert II. Other significant conditions are sufficient conditions.  25. Wes case referred to mediexaminer?  1 ☐ Yes 2 ☐ No.  27. Menner of Deeth	Hospitel: 1 28a. De	Due to (  death but not re	or es e consecutive de sulting In the u	quence of):  underlying ceuse g	26. Plece of D ther: 4∐ Nursing	24a. Was performed to the control of	an autopsy med?  Yas 2 ⊮ No	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?  1 Yas 2 No
25. Wes case referred to mediexaminer?  27. Menner of Deeth  1 2 Neture 5 Pen	Hospitel: 1 28a. De	Due to (  death but not re	or es e consecutive sulting in the u	quence of):  underlying ceuse g  ont 3 DOA O	26. Plece of D ther: 4∐ Nursing	24a. Was performed to the control of	Yes 2□ No an autopsy med?  Yas 2 ☑ No one)  dence 6 □Oth	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?  1 Yas 2 No
25. Wes case referred to medi examiner?  1 Yes 2 No  27. Menner of Deeth  28. Menner of Deeth  29. Accident inve	Hospitel: 1 [  ding stigetion d not be 28e. Ple	Due to (  death but not re  linpatiant 20 e of injury year) ce of Injury - At 1	sulting In the use of the sulting In the sulting	quence of):  underlying ceuse g  ont 3 DOA O	26. Plece of D ther: 4 \( \text{Nursing} \) ury et ork? \( \text{Yes} \) 2 \( \text{No} \)	24a. Was performed to the search (Check only Home 5 Resi 28d. Describe 28f. Location (	Yes 2□ No  an autopsyomed?  Yas 2□ No  one)  dence 6□Oth how injury occur  Street end Numb	3 Probably 4 Unknow  24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?  1 Yas 2 No
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Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 2000 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death MORFE If Unda 8. Data of Birth (Month, Dey, Yea Feb 28, 1 Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) Days 1 M 2 F ,1921 79 174-16-3066 PA. Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. insida City Limits 1 ☐ Yes 2 ☐ No Baltimore Dundalk 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 2750 Moorgate Rd. 21222 USA 13. Was Decedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritai Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) Roller Steel 11 yrs 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Name (First, Middle, Last) Mary Berezonski John Woke 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 2750 Moorgate Rd, Dundalk, Md. 21222 wife Anna Woke 20b. Place of Disposition (Name of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition cemetary, cremetory or other place) May 8 2000 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Middle River, Md. 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Mem Garden 22. Nama and Addrass of Facility Connelly Funeral Home of Dundalk, P.A. nvice Licenses 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part1. Entar tha disaase shock, or haart failura. complications that caused the deeth. On ot antar the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximata Intarvat Batween Onsat and Daath Immediata Ceusa (Final diseasa or condition rasulting in daath) Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in daath) Last MONAY Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy parformad? 1 Tas 2 2400

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

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Baltimore, Maryland 21215-0020

Box 68760

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To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

25. Was casa rafarred to medical

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29a. Certifier

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26. Placa of Death (Chack only ona) Hospital: Othar: Deniursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? injury

28a. Data of Injury (Month, Dey Year) 5 Panding invastigation 1 Natural 2 Accident 6 Could not be 3 Suicide

1 ☐ Yas 2 ☐ No 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stata)

(Check only one) 29b. Signature and title of or

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d, Data signad (Month, Dev. Year)

226 m 23a) (Type, Print)

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30. Nama and addrass of person who con Richard Bennett

31. Data filed (Month, Day, Year)

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Registrar's Signatura

State Registrar

**DHMH 16 Rev 6/95** 

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MAY 0 \$ 2000 / Long

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Yeer **Physician** Month 10 WILLIAMS BILL 2 MAY 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BAYYDEW Months Days Hours Min. Mar. 14,1923 MEDICAL CTR. BALTIMORE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 413-26-3136 Yrs Director TN. Usual Residence of Decedent pernit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Health and Mantei Hyglane. Important: if item 27 is marked other than "natural", or frame 23a or 28a-f show entry fujury or other treumatic event, the Madical Examinar must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Williams Ave. 21222 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Kuehnle & Wilson 6 yrs. Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pete Williams Rachel Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 106 Williams Ave, Dundalk, Md. 21222 Margie Williams wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 6, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) Meadowridge Cemetery 2000 Baltimore, Md. 22. Name and Address of Fecility
Connelly Funeral Home of Dundalk, P.A. 21. Signature of F rice Licen 7110 Sollers Point Rd. Dundalk, Md.21222 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Examiner physicien end s the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2区No 3 Probably 4 Unknown OBSTRUCTIVE TAUNOTCE Records. à Completed 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 27. Manner of Death edical Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 M Natural 24 hours effer deeth.

Funerei Director: Afte sietely tilled in by the fun 1 Tyes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fl (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. Ligense number

Registrar

State

30. Name and address of person who completed cause of death/(Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

2000

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death May Dav Year **Physician** 2:55AM 2000 /Nedicar 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva stre **Examiner** Himore If Undar 24 Hrs. 8. Data of Birth (Month, Day, 7. Age (In yrs. last bijlhday) Yrs. If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Security Number **Funeral** Days 242-20-49 Usual Residence of Deceder 1□M 2 F Director Pegas 1 end 2 should be filed within 72 hours after deeth with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits parmit. Pegas 1 end 2 should be filed within 72 hours after death with the Maryle Department of Haalth and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any Injury or other traumatic event, the Modical Evantment must be notified at pice. mi 1 Pes 2 □ No BAITO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 12. Was Dacedant Evar in U,S. Armed Forcas? 1 \( \text{Yas} \) No If Yas, Give Yaar or Dalas: 4.5 Funeral 13. Was Dacadant of Hispanic Origin? (Spacify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Navar Marriad Married Saltimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: B/ACK þ 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry MARY And Cup Collage (1-4or 5+) Elamantary/Secondary (0-12) 18. Mothar's Nema (First, Middle, Meiden Surnema) (First, Middla, Last) Be Annie 0 inenown 19b. Mailing Address (Street and Number or Rural Routa Number 19a. Informant's Name/Relationship (Type, Print) City or Town, Stete, Zip Code) Mithod of Disposition FAMILY COM.

22. Nama and Addrays of Facility

B. H. Burial 2 Cramation 3 Ramoval from State
Donation 5 Other (Specify) 21. Signature of Pynaral Sarvica Licansee nent 9 BAJTT. MO.212/3 The the deese, or complications that causad the death. Do not antar the mode of shock, or heart failure. List only one cause on each line. N. CARD Approximata Intervel Batwaan Onsat and Daath **Physician** 10min /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner pheumonia e obabl The law requires that the death certificate be executed nding physicien and use es the bunal-transi Sequantially list conditions, if eny, laading to immadiate causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of): PSIS Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the ceuse of death? roscherobic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Wara eutopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificata has the 1 Yas 2 No 1 ☐ Yas 2 NO Hospital or Attending Physician: Be 25. Was casa referred to madical 26. Place of Daath (Check only ona) examiner's Hospital: 1 ☐ Inpatiant 2 ► ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Spacify) P 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Watural efter deeth. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) To the Hospital or Atterview within 24 hours efter de To the Funeral Directo completaly fillad in by the 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, afc. (Spacify) 4 | Homicida 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end mennar es steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date end piece, end due to the causa(s) and mannar stated. 29e. Certifier edicai 29d. Data signed (Month, Day, Yaar) 29b. Signatura and titla of cartifier 29c. License number 38956 use of daath (Item 23a) (Typa, Print) MD, 5601 Loch Ruven Blvd, Baldinore, Mayland 30. Nama engladdress of person 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar **DHMH 16 Rev 6/95** 

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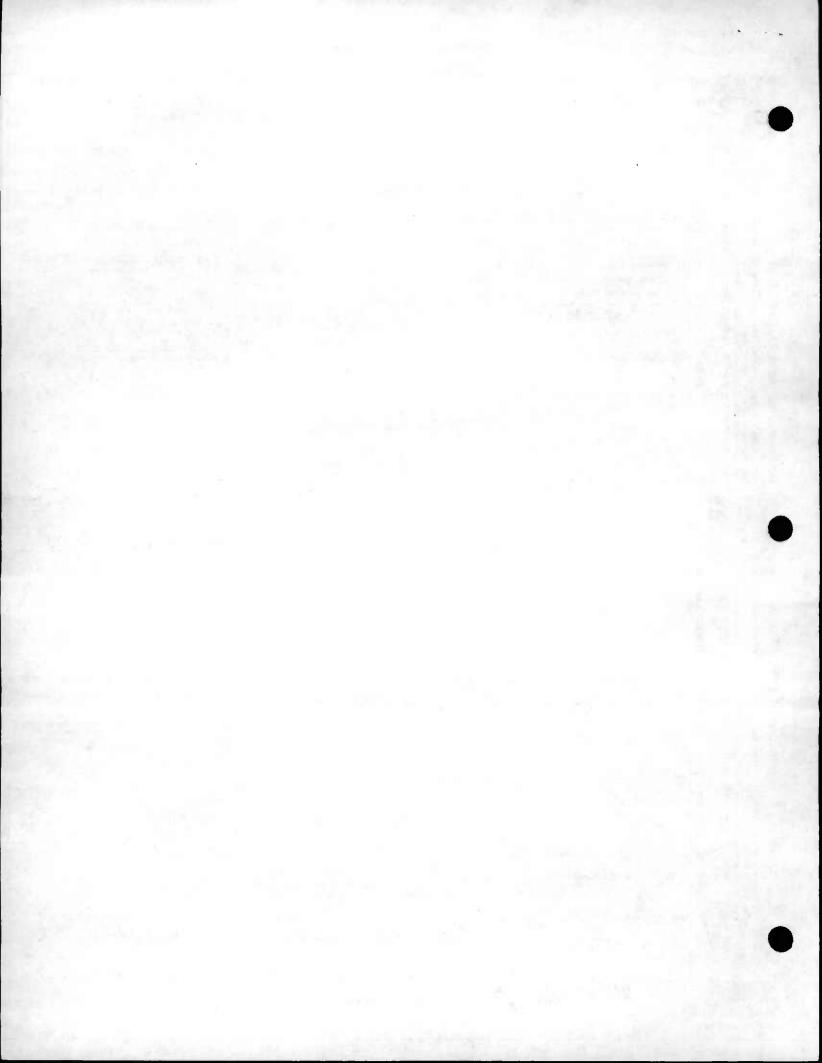
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** Ann Laser Wissman 4 00 4:00 am /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16999 Rivers Reach Lane Hughesville Charles 5. Social Security Number 6. Sex If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days 1□M 2₩F Months Hours 70 Director 579-42-1052 12-10-1929 Washington D.C. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits show 1 ☐ Yas 2 No Director MD Charles **Hughesville** 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? "natural", or items 23s or edical Examiner must be a 16999 Rivers Reach Lane 20637 Funeral U.S.A 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Stetus 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: If Yas, Give Specify: White þ 3 Widowed 4 □ Divorced Yaer or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry filed within 72 Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Home Maker Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
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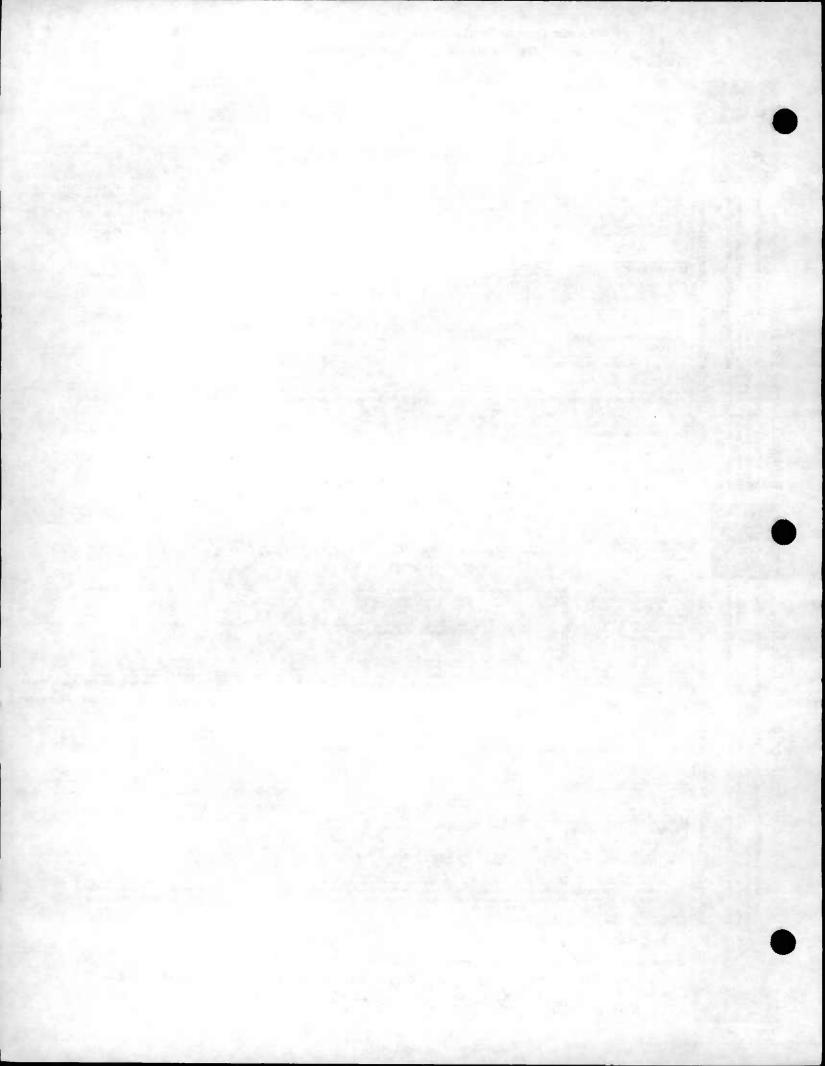
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 

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Agned Forcas?
1-1∆ Yes 2 □ No WW II
If Yas, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Navar Marriad 2 Married Specify: White 1 Yes X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Seagram's Elementary/Secondary (0-12) Coltege (1-4or 5+) Floor Manager Bottling Company 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Howard Bertram Wilson Werra Elv 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Margaret N. Wilson/Wife 7 Battersea Road Ocean Pines, MD 21811 20b. Place of Disposition (Neme of cematary, cramatory or other pleca) 20c. Location - City or Town, Stata 20a Mathod of Disposition Metro Crematory, Inc. 5/3/00 Baltimore, MD 21. Signature of Funeral Service Lice <sup>22</sup>, Nama and Address of Facility Cremation Society of Maryland, Inc. Lynclel Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease of complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Ceuse (Final 4 Days disease or condition rasulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequance of): Part II. Other significant conditions confributing to death but nof rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware eutopsy findings available prior fo complation of cause of death? 24a. Was an autopsy parformed? 1 Yas 2 No 1 ☐ Yes 2 No 25. Was casa rafarred to madical examiner? 26. Ptaca of Daath (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of Injury 28c. Injury et 28d. Dascribe how injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Division of Vital Records, P.O. Box 68760,

The law requires that the death cartificate be executed attanding physician or Attending Physician: s after death.

al Director: After this ce filled in by

**Physician** 

/Medical

Examiner

Funeral Director

p

Completed

8

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylani Department of Health and Mental Hygiane.
Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show with injury or other traumstic event, the Medical Example of the profit of all pages.

**Physician** /Medical

Examiner

Examiner

by Physician/Medical

Completed

Be

10

Certification:

altimore, Maryland 21215-0020

within 24 hours a To the Funeral D completely filled To the Hospital

0

State Registrar

31. Deta filed (Month, Day, Year) MAY 0 5 2000

29b. Signeture end title of certifiar

4 ☐ Homicida

29a. Certifiar (Check only one)



30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

as Hospital 600 North Wolfe Street

Certifying Physician: To the best of my knowledge, death occurred of the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred of the time, date and place, and due to the ceuse(s) end manner stated.

29c. Licansa number

RES-000

29d. Dafa signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

MAX 0 5 2000 James 15 James

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

4.00					te of Death		Reg. No.	11	567
Physician	1. Decedent's Neme (First, Middle, Last Mabel	C. Anady				2. Dete of De	ath 13 <sup>Day</sup> 20	ŎŎ°	3. Time of Death 840 PM
/Medical Examiner	4a Facility Name (If not institution, give Solomons Nursi	street end number)			4b. City, Town, or Solomon	Location of Death		of Death	
Funeral Director	300 24 07/9	7. Aga (In )		thdey) If Und Months	or 1 Year If Under 24 Hr Deys Hours Mir	. (Month, Da	th ly, Year)		ace (State or Forei
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5 28 S	3√2 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U,S.	13. Wes Dec	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue 200 No Specify:	Specify Yes or No rto Rican, etc.)	14. Rac Bla Specif	ce - America ck, Whita, e y: Wh.	
72 h	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's Us (Give kind of w	uel Occupation ork done during most of wi use ratired)	orking	16b. Kind of B	usiness/Ind	ustry
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Delliniii Pa Departmen Important: any injury once.	21. Signature of Funaral Service Licens				nd Addrass of Fecility	Rausch F	uneral 1	Home 1	PA
Physician //Medical Examiner	23a. Part1. Entar the disease, or compishock, or heart failure. List only of limmediata Cause (Finel disease or condition resulting in death)	Муоса	rdia	l infar	ction	ic or raspiratory a	rrest,	1	Approximete Interval Between Onset end Death
B # E		Conge	estiv	e Heart	Failure				
tificate be executed on physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events			onsequance of orillat					
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	3 Suicide 6 Could not be 4 Homicide determined	28e. Piece of Injury - A building, atc. (Spe	icify)			City or To			
To the Hospital or within 24 hours aff To the Funeral Di completely filled in Medical Cer	29a. Certifier Certifying Phys	nician: To the best of my liner: On the basis of axam end manner steted.	nowledge, ination and	deeth occurre Vor investigation	at the time, date end place, in my opinion, death occ	a, end dua to the urred at tha tima,	cause(s) end m data and plece,	anner as sta and due to	ited. the cause(s)
To the comp	29b. Signeture end little of curtifier	no	-	29	D. License number	88	29d. Date signe April		
30	30. Name and address of person who co Rafik Nasr, MD				rince Freder	rick. MD	20678		
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	4	/	2011	20070		

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #16b, per FD, TCHD, 4-19-00, SHS Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dev Veal April 2000 7:52 P.M. Mary Etta Brown 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehabiltation Cen. Chestertown If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Deys 1□M 25€F 218-20-2639 May 22,1920 Maryland Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Maryland Talbot Easton 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 318 South Street 21601 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Stetus Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Someone else's home Elementary/Secondary (0-12) College (1-4or 5+) Some one clac's home Unknown Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Aaron Reddin Ida Thomas 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy Wilson / daughter 318 South Street, Easton, Maryland 21601 20b. Ptece of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 

Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Pomona Cemetery 4/24/2000 Chestertown, Md. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervet Between Onset end Death Immediate Ceuse (Finat disease or condition resulting in deeth) Cardio Respiratory Arrest 20 W/n Autero Salevatic Cardio Vascular Disease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last Due to (or es e consequenca of) Due to (or es e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dementia, DINTypo II, HTN, Glancoma, Arthritis 1 ☐ Yes 2 ☐ No 3 □ Probably 4 Unknown 24e. Wes en eutopsy

Physician /Wedical Examiner

Examiner physician end s the buriel-transit The law requires thet the deeth certificete be executed

**Physician** 

/Medical

**Examiner** 

Directo

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Completed

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**Funeral** 

Director

with the Merylend

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylan Department of Heelih and Mentle Hyglene. The firmocrant: If them 27 is marked other than "natural; or flems 23a or 28a-f show any injury or other traumatic event, the Medical Exertine man be notified at

altimore, Maryland 21215-0020

545

Division of Vital Records, P.O. Box 68760,

Physiclan/Medical Be Completed by Certification: To

been signed by the should be detached

is certificete has t director, pege 2 s

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifice completely filled in by the funeral director, to

Porpland Vase Dy Chronic Roud Insufficency Decubiti 26. Piece of Deeth (Check only one)

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred

28a. Dete of tnjury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

27. Manner of Deeth

Naturel

2 Accident

4 Homicide

3 Suicide

🕰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated.

29b. Signature end title of cartifier

29c. License number

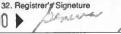
29d. Date signed (Month, Day, Year) 60

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

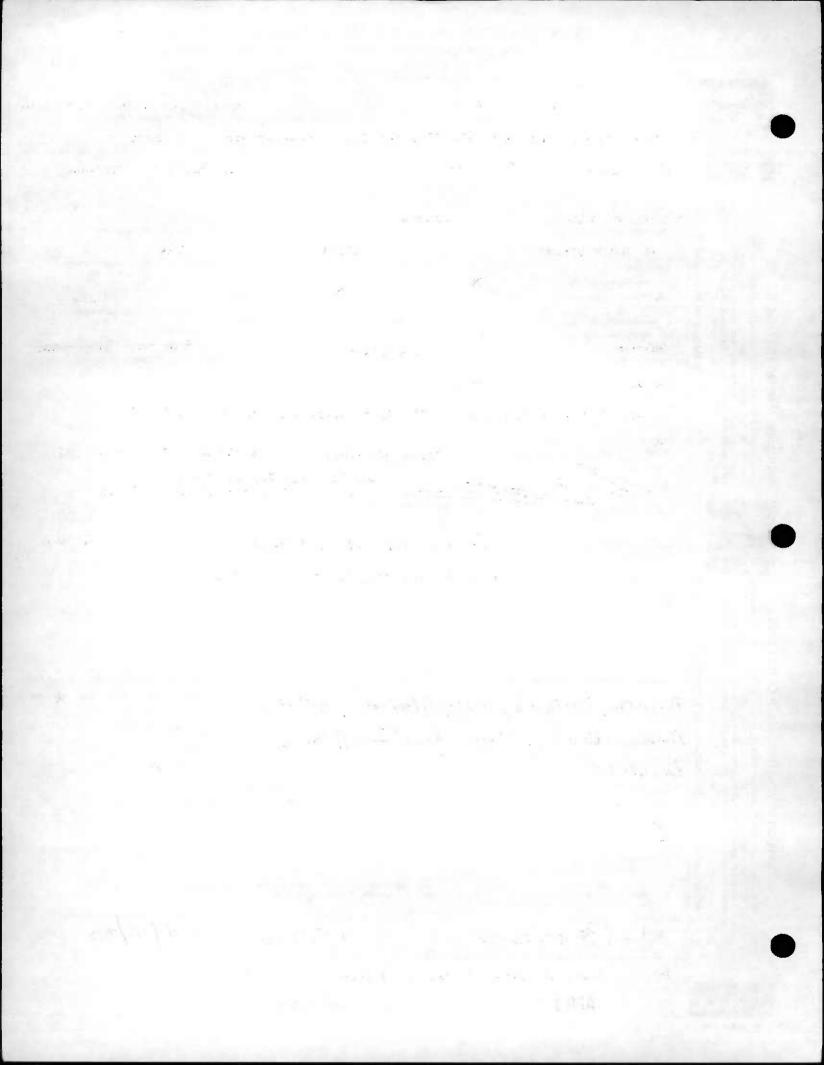
Dr. Stoddard, 100 Brown Street, Chestertown, Maryland 21620

Registrar

31. Date filed (Month, Day, Year) APR 1 9 2000 >



Darker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** DAVID LEROY BREMER APRIL 14, 2000 3:57 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL 8. Date of Birth (Month, Dey, Year) JAN. 7, 19 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 14M 20 F Yrs 250-70-7453 56 1944 FLORIDA Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD SOMERSET WESTOVER 288-1 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 7125 OLD WESTOVER ROAD 21871 U.S.A. Items 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ XYes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus Bleck, White, etc. 'natural', or iter dical Examiner filed within 72 hours after 1X Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 REALTOR REAL ESTATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 86 permit. Pages 1 and 2 should be 1 Department of Health and Mental тагка REV. FREDERICK L. BREMER RUTH TRASK 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Important: If Ibam 27 any injury or other to KAREN B. CHATHAM/SISTER 4631 EVERLEA COURT, PRESTON, MD 21655 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donetion 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY 4/18/00 HURLOCK, MD 21. Signature of Funerel Symice Liquid 22. Name and Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTO EASTON, aum MD 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) 9 YEARS CANCER OF THE LUNG Examiner Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medicai Due to (or as e consequence of): P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2 □ No 3 Probably 4 Unknown Records, ð been sig 24b. Were eutopsy findings aveileble prior to Be Completed 24a. Wes an eutopsy completion of cause of death? page 2 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 1 N Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 5 Pending investigation After 1 XNaturel death. 1 ☐ Yes 2 ☐ No n 24 hours after death.
Ne Funeral Director: A oletely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medicai To the Fune completely f (Check only onel within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier a D42014 APRIL 14, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD

State Registrar

APR 1 7 2000

31. Dete filed (Month, Dey, Year)

32. Registrar's Signature

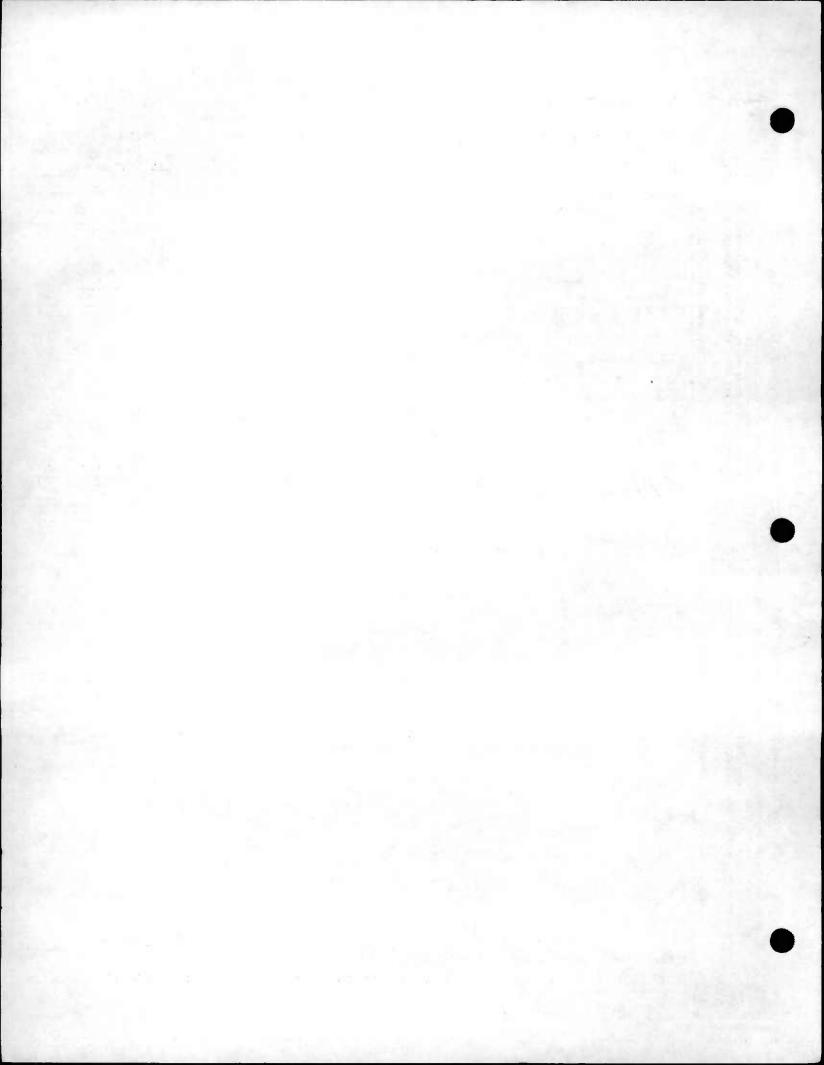
DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Yaar Month Marcelle M. Blount 10 2000 April 8:07PM 4e Fecility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Data of Birth (Month, Dey, Year) Feb. 20, 1 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplece (Steta or Foraign Country) Days 1 M 2 F Yrs. 230-38-9107 66 1934 Virginia Usuat Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 No Yes 2 No Maryland Prince George's Seat Pleasant 10e. Streel and Number 10f. Zip Code 10g. Citizan of What Country? 6404 Greig St. #102 20743 United States 12. Was Decedeni Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ď No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Slalus 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 10th Housewife Private 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) William Mason Maggie Hargrave 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Glenda Van Pelt - Daughter 9315 Parkwood Ave., Douglasville, GA 20b. Place of Disposition (Neme of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition W Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Forest Hills Cemetery 4/19/2000 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signatura of Funaral Sarvice Licenses 22. Nama and Address of Fecility Stewart Funeral Home war 4001 Benning Rd., N.E. Wash., D.C. 20019 23a. Part 1 Entar tha disease, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or respiretory arrest, shock or heart failure. List only one cause on each line. Approximata Intarvat Batween Onsat and Death Immediate Causa (Final disaasa or condition rasulting in daath) Bacterial Endocarditis Dua to (or es e consequence of): Aortic Valve Replacement Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Diseese or Injury that initiated evants rasulting in death) Last Due to (or es a consequence of): Dissection of Aortic Wall Dua to (or es e consequance of): Coagulapathy Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Failure 24b. Wara eutopsy findings aveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Arteriosclerosis General Respiratory Failure, Ventilator Dependent 1 ☐ Yas 2 ☐ No 1 Yes 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 Nnpatiant Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 ☐ Yas 2 No 2 ER/Outpatient 3 DOA 27. Mannar of Death 28c. Injury et Work? 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 1 Naturet
2 Accident 5 Pending 1 Yas 2 No invastigation 3 Suicide 6 Could not be datermined Location (Streat and Number or Rural Routa Numbar, City or Town, Steta) 28a. Pleca of tnjury - At home, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner

polymit. Peges 1 and 2 should be filed within 72 hours after operment of Heelth and Mantel Hygiene. Important: If Item 27 is marked other than "natural", or its any Injury or other traumatic avant, trained any Injury or other traumatic avant, trained any Injury or other traumatic avant, trained and any Injury or other trained and any Injury or other trained and In

Physician

**Funeral** 

**Director** 

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Items 23s or 28s-f short insermant be notified at

death

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Records,

Division of Vital

Directo

Funeral

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Completed

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**Examiner** 

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Physician/Medical Examiner

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Be Completed

Certification: To

Medical

4 Homicide

(Check only one)

29b. Signeture end titla of cartified

31. Data filed (Month, Day, Year)

29e. Certifiar

or attending Physician: The law requires that the death certificate be executed after deeth.

Director: After this certificate has been signed by the attending physicien and

completely filled in by To the Hospital within 24 hours a

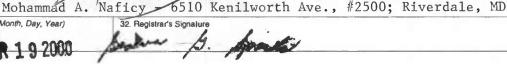
**DHMH 16 Rev 6/95** 

State Registrar

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2 Medical Examiner: On the basic of examiner and marinar stated.



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**ORIGINAL** 

🛣 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date and place, and dua to tha causa(s) and mannar es statad

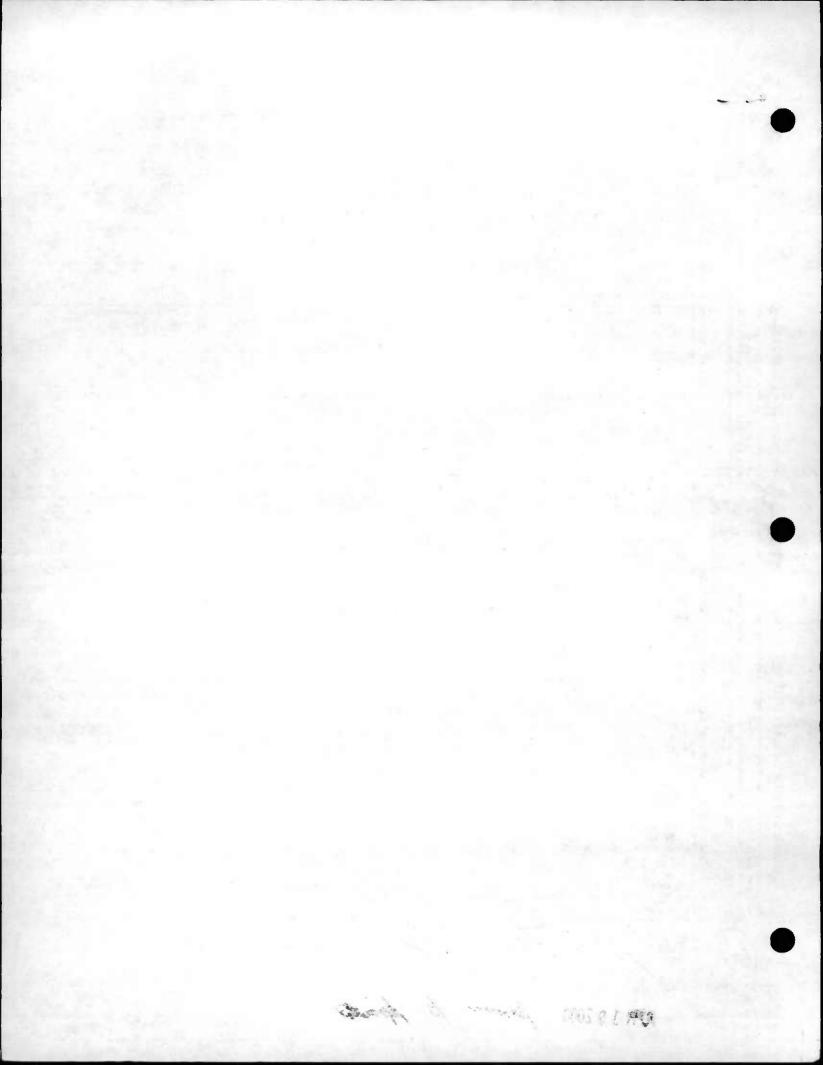
29c. License number

D14182

of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Data signed (Month, Day, Year) 4/18/2000

20737



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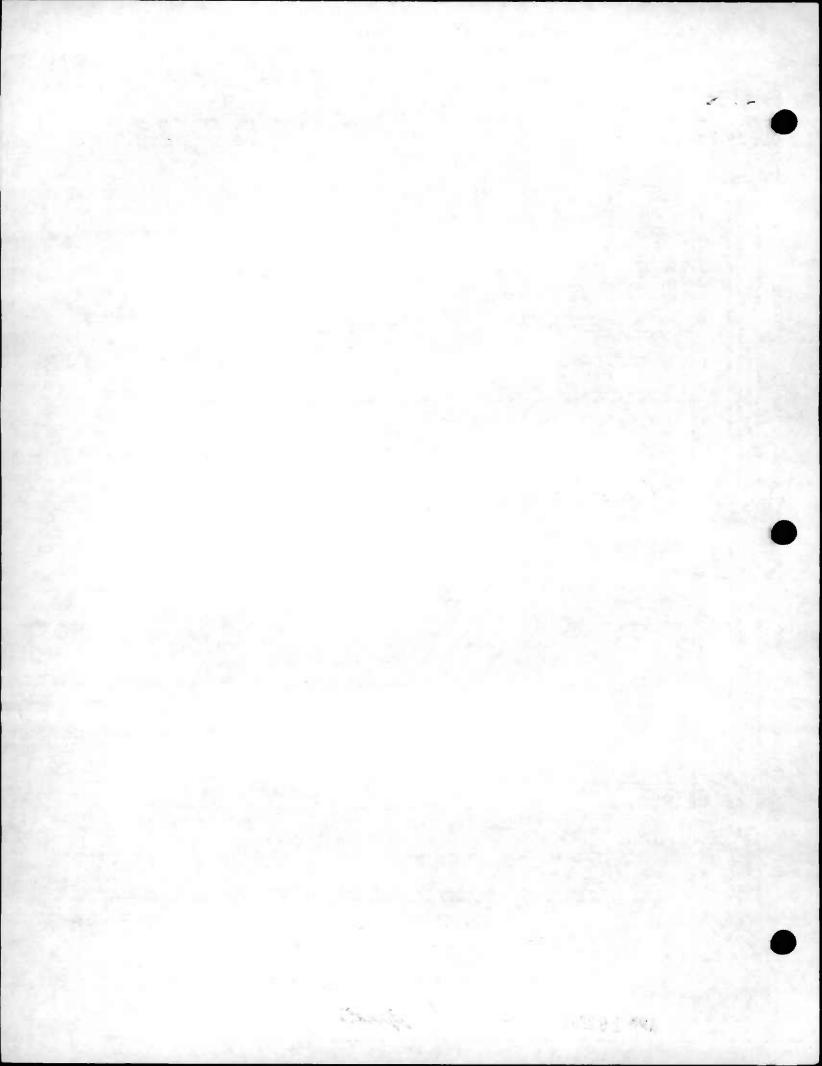
State of Maryland / Department of Health and Mental Hygiene

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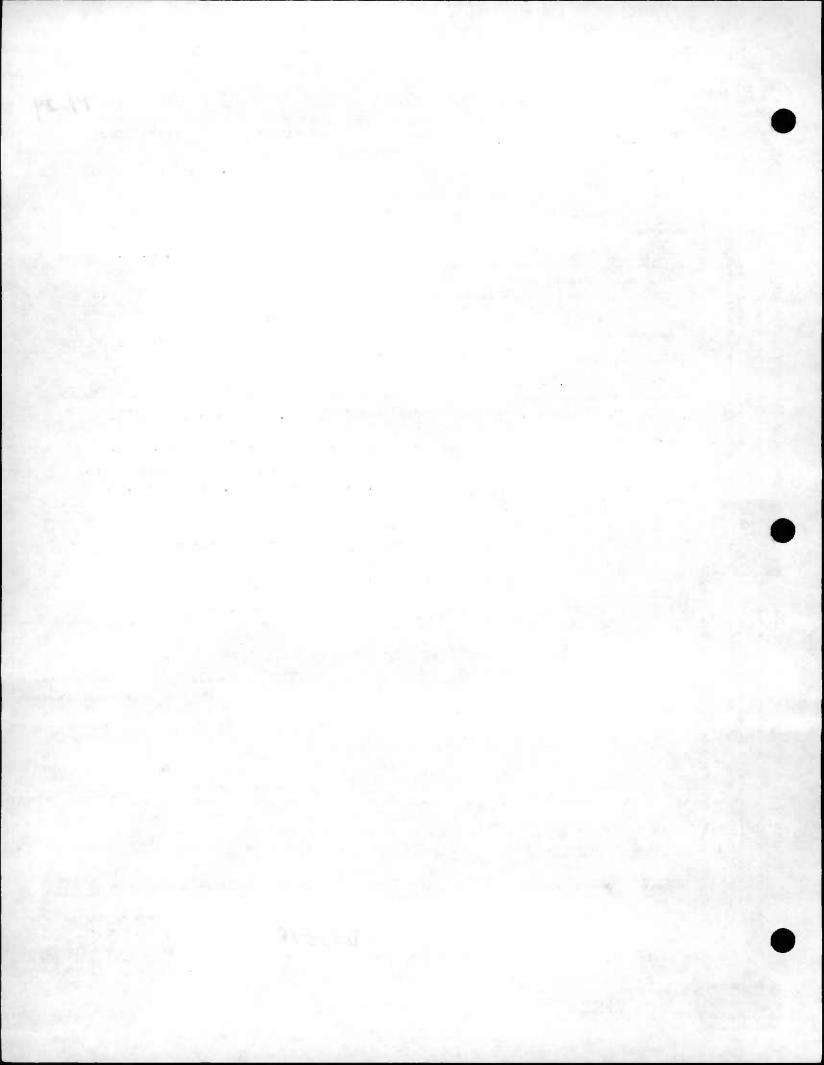
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		State of Maryla	nd / Department of Certificate of		al Hygiene	14573			
	1. Decedent's Neme (First, Middle,				e ol Deeth	3. Time of Death			
Physician /Medical		Allen Kurtz	Chilcoat	An		000 17:24			
Examiner	4e Facility Neme (If not institution,	give street and number)		4b. City, Town, or Location					
W L	Washington Cour	ty Hospital		Hagerstown	Washir				
Funeral Director	5. Social Security Number  219-28-1511  Usual Residence of Decedent	1⊠ M 2□ F	Mantha Davis Haves Min (Month Day Voor)						
Mand	10a. Stete 10b. County	10c. C	ity, Town or Location			10d. tnside City Limits			
uth with the Marylar 23a or 28e-f show the contributed at	MD Washing	ton H	agerstown			1 ☐ Yes 2 ☐ No			
or 28s-f	10a. Street and Number		10f. Zip Cod	•	10g. Citizen ol W	het Country?			
th wit	20067 Old Forge	Road	21742		U.S.	Δ			
Herra Herra	11. Maritel Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 12/Yes 2 No If Yes, Give 1948	Il Yes specify C	etc.) 14. Race Bleck	14. Race - American Indien, Bleck, White, etc. Specify: White				
72 hours	15. Decedent's	Education	16a. Decedent's Usuel Oc	cupation	16b. Kind ol Bus	siness/Industry			
2121 I within lene. then	(Specify only highest (Secondary (0-12)	College (1-4or 5+)	life. DO NOT use rel		Private	Industry			
De di tity de la contra del la contra de la contra de la contra del la contra del la contra de la contra de la contra del la con		st)	28.0	18. Mother's Neme (First,	Middle, Maiden Sumeme	)			
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Par and	19a. Informent's Neme/Retetionship			eet and Number or Rural Route					
and and mark	Bernice G. Chilc			rge Rd. Hagers					
0 82=5	20a. Method ol Disposition  1 Buriat 2 Cremetion 3 4 Donation 5 Other (Spe	□Removal from State Ro	Place of Disposition (Name of cometery, cremetory or other p st Haven Cemet	olece)	-00 Hagersto	City or Town, Stete Wn, MD			
Baltim permit. Pa Department Importanti any Injury state.	21. Signature of Funeral Service Lic	Mark	22. Name and Ad 1601 Pen	<sup>dress of Facility</sup> Rest Ha nsylvania Ave.	ven Funeral Hagerstown	Chapel , MD 21742			
Physician /Medical	23a and Enter the disease, or contained, or heart leiture. List on Immediate Cause (Finat disease or condition	emplications that caused the dealy one cause on each line.	th. Do not enter the mode of o			Approximete tntervel Between Onset end Deeth			
Examiner	resulting in deeth)	a. Due to	(or as e consequence of):	in the	riture	1			
owecuted in and fal-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consequence of):	mour	eran				
0 2 2 2 E	cause. Enter Underlying Cause (Diseese or injury that initieted events	c. Fur	gul Pe	runno					
	resulting in death) Last	o. End	or esta consequence of): Hage Re	nal dise	ase				
Seath death distribution	Part II. Other significant conditions	contributing to death but not re	sulting in the underlying cause	chun in Part f	h Did tohacco use con	tributa to the cause of death'			
ds, P.O. Box 6i	Tath. Other agrinoant conditions	Contracting to death but not re	sunning in the unionlying cause	given in Petti.		3 Probably 4 QUnknow			
r negu shoul				24	a. Wes en eutopsy performed?	24b. Were autopsy lindings aveileble prior to completion of cause of deeth?			
Vital Re- idlen: The law certificate has rector, page 2					1 Yes 2 W No	1 ☐ Yes 2 ☐ No			
ital	25. Wes case referred to medical			26. Place of Death (Chec					
hysicis ni direct	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DOA	Other	☐ Residenca 6 ☐ Othe	r (Specify)			
ding Aries	27. Manner of Death 1 ØNaturet 5 ☐ Pending 2 ☐ Accident investigat	28e. Date of Injury (Month, Day Year)		njury at 28d. De Vork? □ Yes 2 □ No	escribe how injury occurre	od			
Division of attending P at a lone death. All of the tunent and in by the tunent Certification:	3 Suicide 8 Could not determine	28e. Plece of Injury - At building, etc. (Spec	home, ferm, street, lactory, officity)		cation (Street and Number y or Town, Stete)	r or Rural Route Number,			
DIVISI To the Hospital or Attention 24 hours after deat ompletely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, deeth occurred et the ation end/or investigation, in m	time, date end place, end due y opinion, deeth occurred et th	e to the cause(s) end mar te time, date end placa, e	ner es steted. nd due to the ceuse(s)			
To the To the comp	29b. Signature and title of certifier			ense number		(Month, Day, Year)			
	786	28020.	D5	3548	4/25/00				

State Registrar

MOHAM MED

31. Date liled (Month, Day, Year)



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 21, 2000 April Guy Edward Chew, Sr. 7:35 A.M. /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert. 5. Sociel Security Number 6. Sex ↑ M 2 F 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 6. Dete of Birth (Month, Day, Year) March 8, 1917 9. Birthplece (State or Foreign Country) Maryland **Funeral** Months Deys Hours 83 Yrs. Director 579-16-4374 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show spiritury or other treumatic event, the Medical Examiner must be incitied at once. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5820 Mackall Road 20685 USA Funeral 12. Wes Decedent Ever in U,S.
Amned Forces?
1 △ Yes 2 □ No
If Yes, Give 11. Merital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: <u>ک</u> 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Chef Restaurant 17. Fether's Neme (First, Middle, Last) 16. Mother's Name (First, Middle, Maiden Sumeme) Be Willie Chew Daisy Parker ပ 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Toye/Stepdaughter 5820 Mackall Road St. Leonard, MD 20685 20b. Plece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4/27/00 Holland Cemetery Huntingtown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Sewell Funeral Home Bladen 1451 Dares Beach Rd. Prince Frederick, MD 20678 ewell 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Metassatic Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Examiner Examiner umia physicien end s the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Division of Vital Records, P.O. Box 68760, Physician/Medical thet Initiated events resulting in deeth) Last USe es attending been signed by the should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? Aftar this certificate has 1 Yes 2 No 1 ☐ Yes 2 100 To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Manne of Deeth 28a. Dete of Injury (Month, Day Year) 26b. Time of Injury Certification: 28c. Injury et Work? 26d. Describe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 26f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide 26e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture endititle of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2000 ess of person who completed cause of deeth (Item 23e) (Type, Print) Prince Frederick MD ranwala, M. D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State APR 2 4 2000 Registrar

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Physician					Oei	tificate c	Douth			Reg. No.		
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Funeral			1 M 2 T F		Yrs.	Months Da		Min.	8. Date of Birt (Month, De 1/10/.	y, Yeer)	(eer) 9. Birthplace (State or For	
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be notified Director	10e. Street and Numb					10f. Zip Cod			10g. Citizen of What Country			intry?
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era ara	1212 Prince Street 11. Marital Status   12. Was Decedent Ever in U.S.				13. V		rigin? (Spe	city Yes or No	USA as or No- 14. Race - American Indian,			
ai, or items 23a or 28a-f ahor Examiner must be notified at by Funeral Director		d 20VMarried	Armed Forces?		<ol> <li>Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F</li> </ol>			Rican, etc.)	Blac	ck, White,		
by B						I□ Yes 💥 I	:		Specify: white			
"natural", adical Ex leted by			10.000		10. 5. 1					401 15-1-15		
natur adical	(Specify	<ol><li>Decedent's E- only highest gre</li></ol>	ducetion ade com <i>pleted)</i>		16a. Deced (Give I	lent's Usual Oc kind of work do	cupetion ne <i>during</i> mos	st of working	g	16b. Kind of Bu	usiness/Ir	ndustry
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and Maria	19a. informant's Nan				19b. Mailin	g Address (Str				er, City or Town,	Stete Zi	ip Code)
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Henry Chappelle							Month	Dey	Yeer	4. 1
17 6					-	4b. City, Town, or Lo	MIRCOV		2000	10.05 pm
	(If not institution, give					LANHA	A.	4c. County		6 4
5. Social Security I	Number 6.8		ge (In yrs. las	t hirthday) If Unde	r 1 Year	If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
212-12-7 Usual Residence of	458	5 · · · · · · ·	86	Yrs. Months		Hours Min.	8. Date of Birth (Month, Day, JULY 22	,1913	Count	NTON,SC
10a. State	10b. County		10c. City, 1	Town or Location					10	d. Inside City Limits
MD	PRINCE O	GEORGES	BOW	TE.						1⊠Yes 2□No
10e. Street and Nu	1				o Code		10	g. Citizen of V	Whet Count	ry?
13314 KA	TRINKA DRI	VE.			2072	0		UNITED	STAT	ES
11. Marital Status		12. Wes Decedent	Ever in U,S.	13. Was Dece	dent of H	ispanic Origin? (Spe	cify Yes or No-	14. Rac	e - America	n Indien,
1 Never Man	ried 2 Married 4 Divorced	Armed Forces?  1 X Yes 2 If Yes, Give Year or Dates:	No 4-41 10-4	1∏ Yes		an, Mexican, Puerto I Specify:	Hican, etc.)		ck, White, e	
10-	15. Decedent's Edu cify only highest grad	cation	1	16a. Decedent's Usu	al Occup	ation	1	6b. Kind of Bu	usiness/Indu	ustry
15, Decedent's Eigenentary/Secondary (0-12) 12		life. DO I			d of work done during most of working NOT use retired)					
12				MONOTYPE	CAST	ERMAN		U.S. G	OVERN	MENT
	(First, Middle, Last)					18. Mother's Name	(First, Middle, M	laiden Sumem	10)	
HENRY C	CHAPPELLE, S	SR				LOREE		9		
	lame/Relationship (T)				s (Street	and Number or Rura	l Route Number,	City or Town,	State, Zip (	Code)
	APPELLE HO	WARD / D.	AUGHTE			INKA DRIVI				
Oa. Method of Dis	sposition  Cremetion 3 P	lemovel from State	cem	e of Disposition (Na etery, crematory or	other ple			Oc. Location -	City or Tov	vn, Stete
	5 Other (Specify)		HAR	MONY MEMO	RIAL	PARK 3	-30-00	LANDOV	ER,MD	
21. Signature of F	uneral Service Licens	2/1/5	100	22. Name a	LEXA	ss of Facility NDER S. PO	OPE FUNE	RAL HO	ME	
1/1)	n. X.	11/1/1	00			BORO PIKE				747
Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	l5									
		1								
	ificant conditions cor	ntributing to death b	out not resulting	ng in the underlying	cause giv	en in Part I.		_		the cause of death?
Part II. Other signi	1	//	()	1-			1 ☐ Ye	2 No	3 ☐ Prob	ably 4☐ Unknown
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Please Type or Print In Black Indellble Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** April 14, 2000 Clifford Margery Kimball 3:40 AM. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 9421 Rockville Pike Bethesda Montgomery 5. Social Security Number If Under 1 Yeer 8. Date of Birth (Month, Day, Yea April 20, If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Year) 1□ M 2X F Yrs. 91 Director 1908 Missouri 216-68-2296 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, ma Magical Event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9421 Rockville Pike 20814 U. S. A. Funeral 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married If Yes, Give Year or Detes 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willis Kimball Lulu Randall 19a. Informent's Name/Retetionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Randall C. Wight -Daughter 9 Charlesbrooke Road Baltimore, MD 21212 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State 5/1/00 Arlington, Arlington National Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses 5130 Wisc. Ave. NW., Washington, D.C. homasi E. Ker donnba 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months . Congestive Heart Failure Due to (or as e consequence of). Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Lest Due to (or es e consequence of) Years Atrial Fibrillation Due to (or es a consequence of):

**Physician** /Medical Examiner

P.O. Box 68760,

Records,

Division of Vital

Physician/Medical Examiner þ Be Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlat-trensit attending physician end I for use es the burial-trensit Certification: To Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

Hypothyroidism; S/P Clostridium Diffiule Enteritis; Constipation; History Phlebitis; Memory Loss

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Naturel 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a d title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D35579

14 April 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

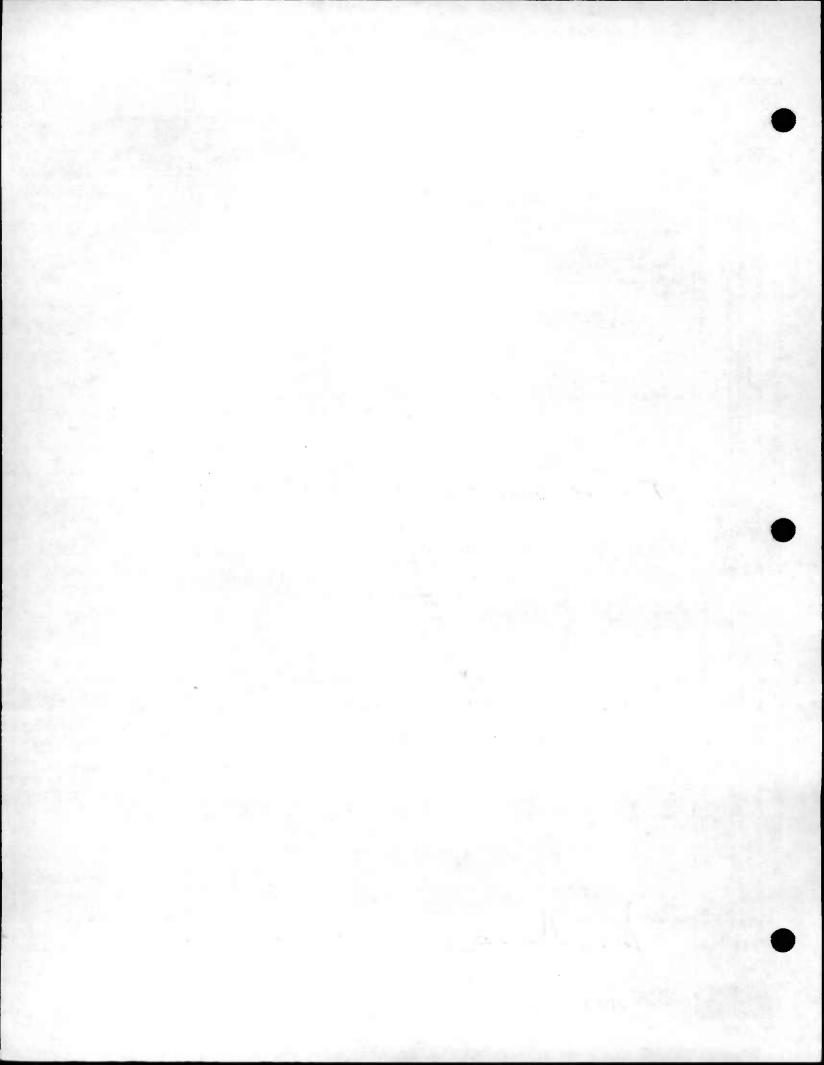
Susan J. Miller, MD. 6844 Tulip Hill Terr. Bethesda, Md. 20816

State Registrar

**APR 17** 2000

31. Dete filed (Month, Day, Year)

32. Registrer's Signature



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

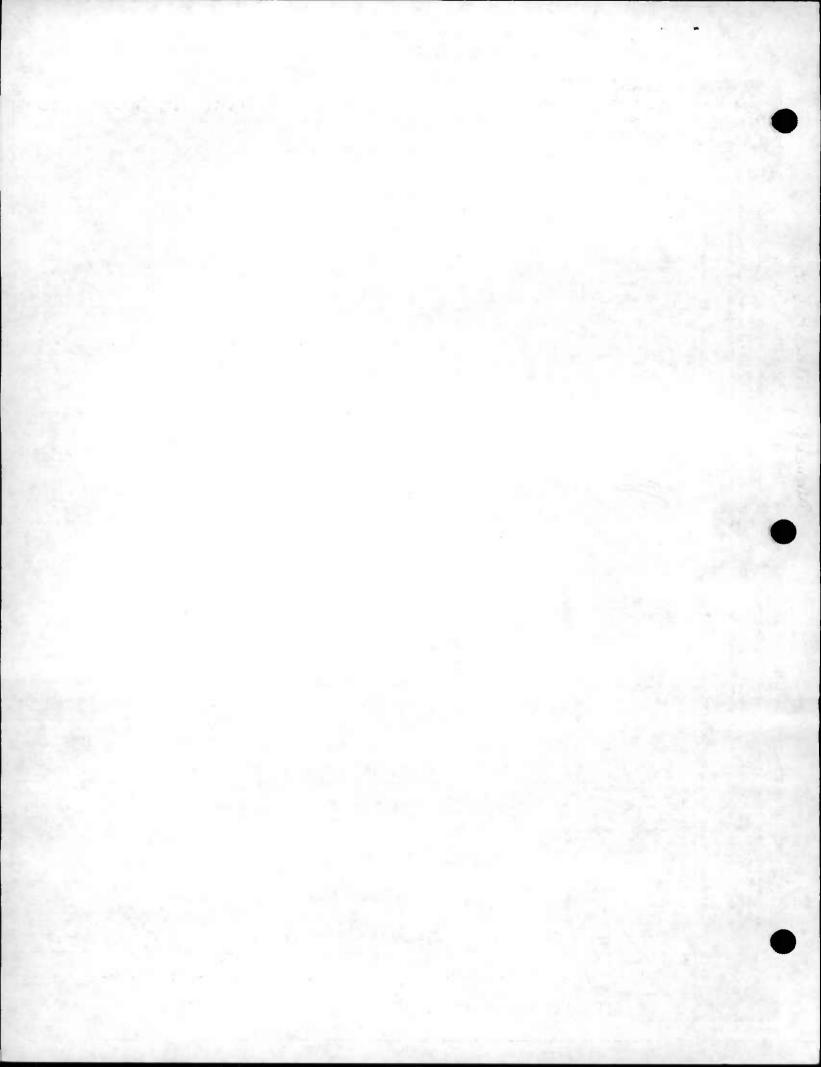
State of Maryland / Department of Health and Mental Hygiene 1457

					C	ertificat	e of	Death			leg. No.	1	
	1. Decedent's Name (Firs	t, Middle, Las	1)							2. Dete of Dee	-	Vaar	3. Time of Dea
ian	Albert Gle	nn DANN	NEBERG							and	25 T	7000 Aeet	0130
cal ner	4a Fecility Neme (If not in			ımber)				4b. City, To	wn, or L	ocation of Deeth			0.00
,	Washington	County	Hospi	ital				На	zers	town		shing	ton
	5. Social Security Number		-	7. Age (In yrs.	. last birthd			If Under	24 Hrs.	8. Dete of Birt (Month, De			place (State or For
	214-46-1012		OM 2□ F	52	Yrs	Months	Days	Hours	Min.	June 8	/, <i>Year)</i>		yland
	Usuel Residence of Dece	dent								June 0	, <u>1947</u>	riai	yranu
	10e. State 10b.	County		10c. C	ity, Town or	r Location						1	Od. Inside City Li
ŏ	Maryland N	Washing	rton			Цаса	*a+	0170					1 ☐ Yes 2 🛭
Director	10e. Street and Number	Nasiiiiig	COII			Hage 10f. Zip		OWIL			10g. Citizen of	Whet Cour	ntry?
	11014 Coffma	an Aszor	2210			102.			2.1				
Funeral		all Avel		edent Ever in U	10 1	13 Was Door	ant of I	Hienanic Ori		740 pecify Yes or No-	14 Ba	USA ce - Americ	
S	11. Marital Status 1 ☐ Never Married 2	Manufact	Armed F	orces?	J,S.   1	If Yes, spe	ify Cub	an, Mexican	, Puerto	Rican, etc.)		ck, White,	
by F	1 □ Never Married 2		If Yes, G	2⊠ No ive		1 🗆 Yes	No No	Specify:			Specia	y: wh	nite
			Year or E	Jates:	10 B	- 4- N- 11-	10				405 141-1-1-1		
Completed	(Specify onl	ecedent's Edu y highest grea	icetion le <i>completed)</i>		160. De	ecedent's Usua live kind of wo le. DO NOT us	k done	during mos	of work	ing	16b. Kind of B	usiness/in	dustry
E D	Elementary/Secondary	(0-12)		(1-4or 5+)						perviso		a+ a+	1
	12	4 41-4-41- 1 43	0		auti	OIIIO C I V E	56			_			e police
Be	17. Fether's Name (First, Albert H.		ara						_	e (First, Middle,		110/	
2	AIDELL II.	Dannet	erg					l	atn	ryn Den	Lon		
	19a. Informant's Name/R									rei Route Numbe			
	Marleen E. I	annebe	rg - w					an Ave	enue	, Hager	stown,	Mary1	land 2174
	20a. Method ol Dispositio				Place of Di	sposition (Ner	ne of ther ple	ice)	1	Date	20c. Location	- City or To	own, State
	1 ☐ Buriel 2 ☐ Crei			State		town C			4	-28-00	Hager	stown	, Maryla
	21. Signature of Fuperel			200	agerb				WAT NIE	NICH FUN			, maryra
		At	W.	11.		F-1							217/0
	10	001	///	um	Ma					, Hager		Md.	21/40
	23a. Part 1. Enter the disc shock, or heart failu	eese, or comp re. List only o	lications that ne cause on	ceused the dee each line.	th. Do not	enter the mod	e of dyi	ng, such as	cardiec	or respiretory er	rest,	i	Approximate Interval Between
					,		,					1	Onset and Deat
	Immediate Cause (Final disease or condition		(	Cardy a	Daer	me s	ho	ck				1	
	resulting in death)		е	Due to (	or as a con	sequence of):	_					1	
ē			(	Ing tral	10	Brack	ne			bleed		1	
Examiner	0		b	Duato	Or 90 0 000	coguence of):							
Exa	Sequentially list condition if eny, leeding to immedia cause. Enter Underlying Ceuse (Diseese or injury	ate	A	- La	0000	642 70		Hina	1	bleed	na	1	
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edical	resulting in death) Last		(	Due to (	or es a con	sequence or):	-	do	100	10	,	1	
3			d	YUDEUS		acous	-	SPO	-01	7		1	
Physician												1	
ysic	Part II. Other significant					, ,	-	ven in Part I		23b. Did 1	obacco uae co	ontribute to	o the causa of de
	Cin	no les	Ausen	lar o	tache	Jaava	ra			10	res 20 No	3 Pro	bably 4 Unk
by	24	VAV	0		- 1	/	,					1	
Pe										24a. Was	an autopsy med?	av	ere autopsy lindir eilable prior to
Completed													mpletion of cause death?
me										101	es 24No		Tyes 25 No
	25 Man 2000 (2	madical							-1.5			1	_ 100 2111110
Be	25. Was cese referred to examiner?	- +	Hospital:	/			. 0	her:		th (Check only o			
. To	1 Yes 20 No		119		ER/Outpa		A	4LINU	rsing Ho	ome 5 Resid			(y)
0		Pending .	28e. Dete (Mor	of injury oth, Dey Year)	28b. Tim Inju		Bc. Inju		Ma	28d. Describe l	iow injury occu		
cat	2 Accident	investigation Could not be				М		Yes 2	140				
E	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	determined		e of Injury - At I ling, etc. (Speci		, street, factor	, office			28f. Location (S City or Tox		ber or Run	el Route Number,
Certification:													
	29a. Certifier 191	ertifying Phy	sician: To the	e best of my kn	owledge, de	eeth occurred	at the ti	ime, date en	d plece,	and due to the	euse(s) and m	enner as s	steted.
edicai	(Check only 2 1 %	redical Exami		pasis of examination of steel and the steel	ation and/o	rinvestigation	in my	opinion, dea	in occur	red at the time,	Date end place	, ena due t	o ine cause(s)
M	29b. Signature and little of	certifier				29	. Licen	se number			29d. Date sign	ed (Month,	Day, Year)
	1	166	_	A	m-	P.	D	00 41	13:	1	04	1251	2000
	20 Name Adaptions	maraon uta	omeleted	ro of their fire	m 22a) /T	no Drint	0	201	25 1	1 - 1	- ( /	-/	
	30. Name and eddress of	person who c	P 12 C	Se or geeth (Ite	ил 239) (Ту	pe, rrint)	3	78	wi	>4.	-	,,,,,,,	(10)
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te	31. Date filed (Month, Day		32.	Registrar's Sign	nature	4 .	-	,					
ar	ADI	9 6 7	10 10 1	A PROPERTY OF		1 6	-	1					

DHMH 16 Rev 6/95

Danneberg, Albert Glenn Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician				Cillicato	of Death		Reg. No.	140/9	
Privsician	1. Decedent's Nama (First, Middla, Last)					2. Data of D	eath Day	Year 3. Tima of Death	
/Medical Examiner	Virginia Ine		7		4b. City, Tow	Apr:	11 16,	2000 1115 a	
Funeral Director	The Memorial  5. Sociel Security Number  214-30-8549  6. Sex	Hospital	yrs. last birthda Yrs.	Months	Eas	ton		lbot 9. Birthplaca (Stete or Foreign Country) South Carolina	
Age and	Usual Residence of Decedant  10a. Stata 10b. County	10c	: City, Town or	Town or Location 10d. Inside City Limit					
ner death with the Maryis therms 23s or 28s-f sho ther must be notified at Tuneral Director	Maryland Caroline	r	Denton	101. Zip (	Code	,	1 √as 2 No		
ath with 123s or 23s or	512 Gay Street			21629			USA		
Eran by F	11. Marital Status  1 Never Marriad 2 Married  3 Widowad 4 Divorced	I2. Was Decedent Evar i Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Detas:	in U,S. 13	3. Was Decede If Yes, speci	ont of Hispanic Original Cuban, Mexican, Mexican, Mexican, Mexican, Mexican, Marina Control	or No- 14. Raca - Amarican Indian, Black, White, etc.  Specify: Black			
fical	15. Decedent's Education (Specify only highast grade complated)			(6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of B	usinass/Industry	
t, the Medical Completed	Elamantary/Secondary (0-12)		Pharmacy Clerk			Denton Pharmacy			
STAP 0	17. Fathar's Nama (First, Middla, Last)					s Nama (First, Middl		na)	
sumetic er	Timothy Mi  19a. Informant's Name/Relationship (Type	10h Ma	niling Addense	Essie	or Rural Routa Num	Pinder	State Tip Cadal		
77 is my traum	Portia M. Thomas/I		_		aston, Mary				
if item 27 or other tr	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Crametion 3 ☐ Re	amoval from Stata	ob. Place of Dis cemetery, ci	sposition (Name tremetory or ott	e of er place)	Data	20c. Location	City or Town, Stata	
Injury 36	4 Donetion 5 Other (Specify)  21. Signature of Funeral Service License			22. Nama and	Address of Facility			New Market, Md.	
F 5 8	1///			ineral Hom Easton,Mar		601			
serificete be axecuted ding physician end as as the burlei-transit	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	Dua t	to (or as a cons	sequence of):					
or use									
for us	Pert II. Other significant conditions conf	ributing to death but not	resulting in the	o underlying ca	use given in Part I.		/		
letached for us Physician	Pert II. Other significant conditions con	ributing to death but not	resulting in the	o underlying ca	use given in Part I.		i tobacco use co		
d by the attand letached for us Physician	Pert II. Other significant conditions con	irlbuting to death but not	resulting in the	e underlying ca	use given in Part I.	1[ 24a. Wa	/		
ate has been signed by the attand paga 2 should be detached for us Completed by Physician/	Pert II. Other significant conditions con	iributing to death but not	resulting in the	e underlying ca	use given in Part I.	24a. Wa	Yee 2 No	3 Probably 4 Unknow  24b. Wara autopsy findings evailable prior to completion of cause	
ate has been signed by the attand page 2 should be detached for us	25. Was casa raferred to medical axaminar?		resulting in the	e underlying ca	26. Place o	24a. Wa	s an autopsy tormed?	3 Probably 4 Unknow  24b. Wara autopsy findings evailable prior to completion of cause of death?	
this certificate has been signed by the attand rat director, page 2 should be detached for us.  To Be Completed by Physician.	25. Was casa raferred to medical axaminar?  1  Yas 2 No He Panding	ospital: 1 Inpatient 28a. Data of Injury	2 ☐ ER/Outpati	ient 3 DO/	26. Place (  Other: 4 ☐ Nurs c. Injury at Work?	24a. Wa per 1 Color Deeth (Check only sing Homa 5 Re 28d. Describe	s an autopsy tormed?	3 Probably 4 Unknow  24b. Wara autopsy findings evailable prior to completion of cause of death?  1 Yas 2 No	
ther death. Irector: After this certificate hes been signed by the attand In by the funeral director, page 2 should be detached for us rtification: To Be Completed by Physician/	25. Was casa raferred to medical axaminar?  1 Yas 2 No He 27. Manner of Death	ospital: 1 inpatient	2 ER/Outpati	tient 3□ DO/ a of 28 y M	26. Place of Other: 4 \( \triangle \	24a. Wa per 1 Check only sing Homa 5 Re 28d. Describe	s an autopsy tormed?  Yes 2 No one)  sidence 6 Other how injury occurrence.	3 Probably 4 Unknow  24b. Wara autopsy findings evailable prior to completion of cause of death?  1 Yas 2 No	
flar death. Irector: After this certificate hes been signed by the attand In by the funeral director, page 2 should be detached for us rtification: To Be Completed by Physician/	25. Was casa raferred to medical axaminar?  1	ospital: 1 inpatient 28a. Data of Injury (Month, Day Yea	2 ER/Outpati 7) 28b. Time injury At home, farm, secity)	itient 3 DO/	26. Place of the control of the time, date and	24a. Wa per 1 Check only sing Homa 5 Re 28d. Describe 0 28f. Location City or T	s an autopsy tormed?  Yes 2 No Yes 2 No Yes 6 Otto Show injury occur (Street and Numbown, Stata)	completion of cause of death?  1	
the death.  Irector: After this certificate has been signed by the attand in by the funeral director, page 2 should be detached for us rtification: To Be Completed by Physician/	25. Was casa raferred to medical axaminar?    Yas 2   No	ospital:  28a. Data of Injury (Month, Day Yea.  28e. Placa of Injury - A building, atc. (Sp	2 ER/Outpati 7) 28b. Time injury At home, farm, secity)	ient 3 DO/ a of 28 y M street, factory, eath occurred at investigation, i	26. Place of the control of the time, date and	24a. Wa per 1 Check only sing Homa 5 Re 28d. Describe 0 28f. Location City or T	S an autopsy tormed?  Yes 2 No  Tone)  Sidence 6 Oth Show injury occur  (Street and Numb own, State)  a cause(s) and min, date and place,	3 Probably 4 Unknown  24b. Wara autopsy findings evailable prior to completion of cause of death?  1 Yas 2 No  ner (Specify)  Tred  Der or Rural Routa Number,	
Physicien: The law requires that the death or this certificate has been signed by the attand rat director, page 2 should be detached for us a To Be Completed by Physician.	25. Was casa raferred to medical axaminar?    Yas   2   No	ospital:  28a. Data of Injury (Month, Day Yea  28e. Placa of Injury - A building, atc. (Sp  lcian: To the best of my er: On tha basis of axam and mannar stated.	2 ER/Outpati r) 28b. Tima Injury At homa, farm, secify) knowledge, deinination and/or	ident 3 DO/ a of 28 y M street, factory, ath occurred at investigation, i	26. Place of Other: 4 Nurse. Injury at Work? 1 Yes 2 Nurse office the time, date and n my opinion, death	24a. Wa per 1 Check only sing Homa 5 Re 28d. Describe 0 28f. Location City or T	S an autopsy tormed?  Yes 2 No  Tone)  Sidence 6 Oth Show injury occur  (Street and Numb own, State)  a cause(s) and min, date and place,	3 Probably 4 Unknow  24b. Wara autopsy findings evailable prior to completion of cause of death?  1 Yas 2 No  nar (Specify)  Tred  per or Rural Route Number, enner es stated. end due to the cause(s)	

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

				Oldio Ol	wai yiai		Certifica			i woman ny	Reg. No.	14	200		
		1. Decedent's Name (Firs	t, Middle, Lasi	)						2. Dete of De	ath	V	3. Time of Deeth		
	Physician • /Medical	Edna	Elizab	eth	Dy	er				April	, 16	2000	8:00 a		
9.	Examiner	4a Facility Name (If not in	stitution, give	street and numb	per)				4b. City, Town, o	r Location of Deal	h 4c. Coun	ty of Death			
		WILLIAM HI	LL MAN	OR					EAST	ON	TAI	вот			
	Funeral	5. Social Security Number	6. Sa	x 7.	Aga (In yrs.	last birti		dar 1 Year	If Under 24 H	rs. 8 Date of Bi					
ш	Director	578-62-3095	10	M 2XX	93	١	rs. Month	os Days	Hours Mi		7,1906	MARYI	ace (State or Foreign try) A.NTD		
Н	70	Usual Residence of Dece								10021	7.3.1.200				
	ylan how		County		10c. Cit	y, Town	or Location				10d. Inside City Limit				
	Ma P-f- The	MD	TALBO	OT EASTON											
	1 2 2 P	10e, Street and Number	,				10f.	Zip Code			10g. Citizen o	f What Coun	try?		
	Nwit 3a c	716 WAYS	TDE AVI	ENHE				21	1601		II	SA			
	iter deeth with the Ma r items 23s or 28s-fe direct mat be notified Funeral Director	11. Marital Status	12. Was Decedent Evar in U,S Armed Forces? 1 Yes 2 2 No			13. Was De			(Specify Yes or Ne erto Ricen, etc.)		ace - America				
0	Fr in Francisco	1 Never Married 2	1 Yes 2	es./ ZNo					erto Hicen, etc.)		ack, White, e				
05	Pages 1 and 2 should be filed within 72 hours a near of Heath and Mantel Hygiena. Inti of Heath and Mantel Hygiena. Inti if Itam 27 is marked other than 'natural', ourly or other traumatic event, the Medical Example of the Traumatic event of	3 X Widowed 4 □ D	ivorced	If Yes, Give Year or Date	es:	1 ☐ Yes 2 🕅 No Specify:			Specify:			WHITE			
9		15. D	ecedent's Edu			16e.	Decedent's U	suel Occu	pation		16b. Kind of	Business/Ind	ustry		
215		Elementary/Secondary	highest grad	e completed) College (1-4	or 5+)		life. DO NO	work done use retire	during most of w	rorking					
217		8	(0-12)	-0-	O( 3+)	10	SEAMST	RESS			CLOT	HING			
P		17. Fathar's Nama (First, I	Middle, Last)						18. Mother's N	ame (First, Middle					
au		JOSEPH MURP	HY						MARY	MAGDELIN	NE WADE				
ī		19a. Informant's Name/Re	elationship (T	rpe. Print)		19b.	Mailing Addr	ess (Stree	t and Number or	Rural Route Number, City or Town, State, Zip Code)					
Ž								100							
é,		DORIS M. BU		DAUGHT	20b. P	lace of	Disposition (f y, crematory of	IDE A	VENUE,	EASTON, Date	4D 2160 20c. Location	- City or To	wn. State		
100		1XXBurial 2 ☐ Cren	nation 3 🗆 F												
tin		4 Donation 5 Other (Specify) ST. JOSEPH'S CEMETERY 4-19-00 CORDOVA,  21. Signature of Funeral Service Coarses  22. Name and Address of Facility									VA, MD				
Ba	permit. Departr imports any inje	* Many	-71	1/10	W/C	FSF	FELLO	WS, H	HELFENBE	IN & NEW	NAM FUN	ERAL H 21601	OME, P.A.		
		23a. Part1. Enter the dise shock, or heart failur	ase, or compl	cations that cau	sed the deat	n. Do n							Approximate Interval Between		
	Physician	onoon, or nout rand	o. List offiny of			1	1		/ 0			1	Onset and Death		
A	/Medical	Immediate Cause (Final disease or condition		congestive heart failure						ura					
	Examiner	resulting in death)		Due to (or as a consequence of):					1			verks			
	خِ السحيح			^		chia chia consequence on.							11-11		
	d insit	The state of the state of		) (C	MAC	, 5	TEND	673				100	LATS		
,	law requires that the death certificate be executed as been signed by the ettending physician and 9.2 should be detached for use as the burial-transit npleted by Physician/Medical Examiner	Sequentially list condition if any, leading to immedia ceuse. Enter Underlying Couse (Disease or injury that initiated	s, te		Due to (o	rasac	onsequence o	n):							
68760,	be siclar	Ceuse (Disease or injury that initiated events	~	s	Disable (see a see a								····		
387	ficate be physicial is the burner edical	resulting in death) Last			Dua to (o	as a co	onsequence o	f):							
	ding p			d											
Box	at the death ce d by the ettendii etached for use Physician/R														
o	tha e da	Part II. Other algnificant of	onditiona cor	tributing to deal	th but not res	ulting in	the underlyin	g ceuse gi	ven in Part I.	23b. Did	tobacco use o	ontribute to	the cause of death?		
<u>~</u>	d by estac	CAPNIA	11 ~	discions					Yes ZINo	3 Prob	ably 4 Unknow				
	res that the da signed by the e be datached i by Physic	0100	7	who	9 4	110	.,, _								
ord	v require been sig should t	1	nia	/							an autopsy ormed?	24b. We ava	re eutopsy findings illabla prior to		
Š	The law requir	- and								-			npletion of ceuse leath?		
æ	0 - 0 -									10	Yes 2 No	1	Yes 2□ No		
ā	certificate rector, per	25. Was cese referred to	madical						00 01				7100 20110		
Vital Records,	sicia certification	examiner?		fospital:				Ot Ot	har /	eath (Check only					
of	his h	1 Yes 2 No		1 🗆 Ing		ER/Out 28b. T	patient 3	DOA	4 Nursing	Homa 5 ☐ Res	idence 6 ∐O how injury occ		)		
2	tal or Attanding P rs aftar death. al Director: After I led in by the funer Certification:		Pending	28e. Date of (Month,	Day Year)		ijury	28c. Inju Wo		200. Describe	now injury occ	JII 60			
Division	Attending r death. Actor: After by the fune ification	2 Accident 3 Suicide 6	investigation Could not be				М		Yes 2□No						
≥	after d Direct d in by	4 Homicide	datermined	28e. Place of building	I Injury - At ho , etc. (Specify	me, far	m, street, fac	ory, office			(Street and Nur wn, State)	nber or Rura	Route Number,		
0	Ital Cel														
	n 24 hours n 24 hours ne Funer plately fill edical									ce, and due to the					
	he H he F plate	one)	CANCAL CARIES	and manne	r stated.	and	- or miredilyali	eri, iii iiiy i	opinion, udani 00	Constant at the thirty					
	To the Hospital or J within 24 hours after To the Funeral Dire complately filled in t Medical Certi	29b. Signature and title of	certifier	0	111	7			se number		29d. Date sign	ed (Month, I	Day, Year)		
		+ Hele	Jus		VV.			DZ	5750		4/12	100			

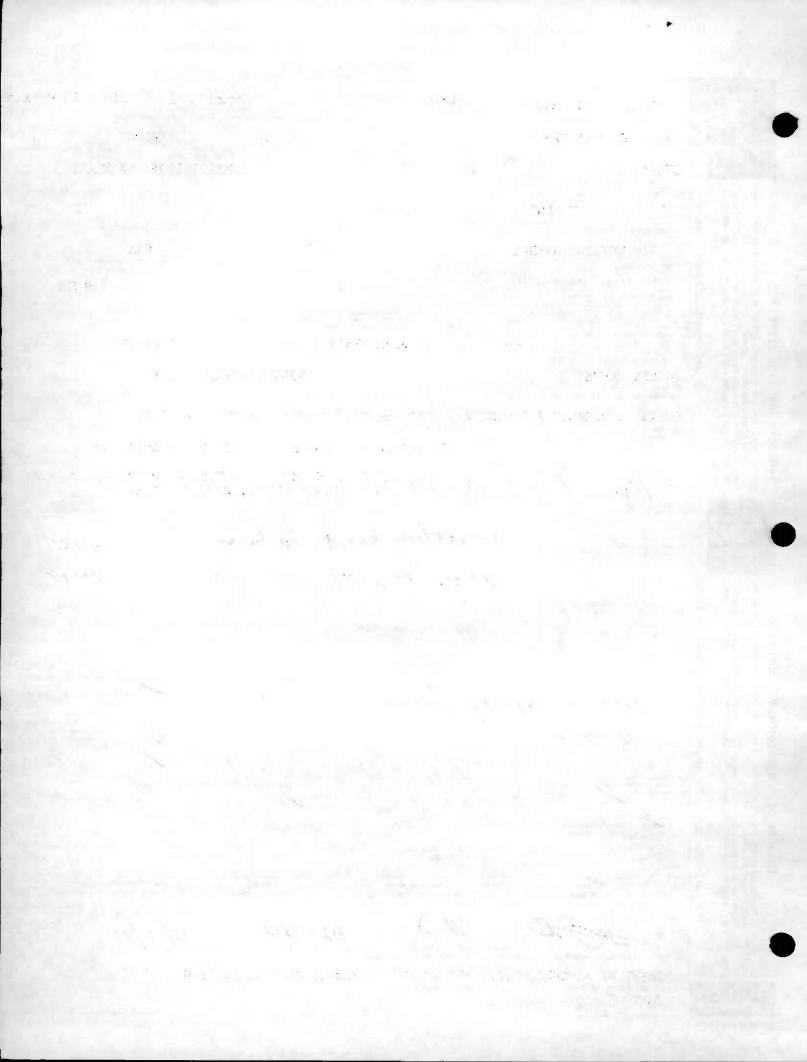
State Registrar ROBERT B. SANCHEZ, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

APR 1 7 2000

Apartle

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)



**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

with the Marylend

permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryler Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinat must be notified at

Baltimore,

and the 98 signed by the a peen hes this certificate director After this funeral c 5

Physician/Medical

þ

Completed

Be

that the death certificete be executed The law Attending Physician: or Attending efter death. filled In I

o. Division of Vital

Certification: To To the Hospital of the Hospital of the Funeral D Registrar

Medical 29b. Signature and title of certifier 160BBAT

1 Natural

2 Accidant

3 Suicida

29a. Cartifiar

4 Homicida

(Check only one)

Clara

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

29c. Licansa number D52455

1) Cortifying Phyaician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

1 ☐ Yas 2 ☐ No

29d. Date signed (Month, Day, Yaar) 2000

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) MORECINO MO

13952 BARTIMORS AVS MARYCAND 20707 consa

APR 2 1 2000

5 Panding

6 Could not ba

invastigation

32. Ragistrar's Signature

AN 15 DESCRIPTION OF THE SERVICE OF

THE RESERVE THE STREET

			2. Date of Month	Day	Year	3. Time of Death	
			Apri		2000	12:20 PM	
			on Location of Direction of Dir		th 4c. County of Deeth Prince George		
		If Under 24					
Yrs. Mont	ths Days	Hours	Min. (Montf	30, Year)	45 Wash	pleca (Stete or Forei intry) Tacoma, nington	
own or Location						10d. tnside City Limi	
age City	V				1 ☑ Yes 2 □ N		
				10g. Citizen of Whet Country?			
	20	722					
			or No- c.) 14. Race - American Indien, Bleck, White, etc. Specify: Black				
6a. Decedent's U	Jsual Occur	pation		16b. Kind	d of Business/Ir	ndustry	
(Give kind of work done during most of working life. DO NOT use retired)				ng			
Mail Cl			U.S. Postal Servi				
18. Mother's Name (				(First, Middle, Maiden Surname)			
Ruth M. Marsha				all	.11		
19b. Mailing Addr	ress (Street	and Number	or Rural Route N	umber, City or	Town, Stete, Zi	ip Code)	
		nue, C	ottage (	City, Ma	aryland	20722	
e of Disposition ( etery, cremetory of	Name of or other pla	ce)	Date	20c. Loca	ation - City or T	own, State	
Lincoln	Ceme	etery	4-15-0	00 Bren	twood,	Maryland	
22. Name	22. Name and Address of Facility						
						20011	
e consequence					Lacase		
e consequence					ISEASE		
a consequence of	of):				I.SEASE		
a consequence of	of):						
	of):	ven in Part I.	23b.	Did tobacco u	se contributa l	to the cause of deat obably 4 ⊠ Unkno	
a consequence of	of):	ven in Part I.	23b.		se contributa l	to the cause of deat obably 4쩐 Unkno	
a consequence of	of):	ven in Part I.	236.	Did tobacco u	se contribute I		
a consequence of	of):	ven in Part I.	23b.	Did tobacco u 1  Yes 2	se contributa I	Vere eutopsy findings veileble prior to ompletion of cause	
a consequence of	of): of): ng cause gir	26. Place of	23b.	Did tobacco u  1 Yes 2  Wes an eutops verionmed?	se contributa I	Vere eutopsy findings veileble prior to ompletion of cause f deeth?	
a consequence of	of): of): of): of): Od Ott	26. Place of	23b.  24a. 1	Did tobacco u  1  Yes 2   Wes an eutops serformed?  U Yes 2   Did Yes 2   Did Yes 6   Residence 6	se contributa I  No 3 Pro  y 24b. W  co  of  No 1	Vere eutopsy findings verileble prior to ompletion of cause f deeth?	
a consequence of	of): of): of):  DOA Of  28c. Inju Wo	26. Place of	23b.  24a. \ 24a. \ 1 Death (Check or	Did tobacco u  1  Yes 2   Wes an eutops berformed?	se contributa I  No 3 Pro  y 24b. W  co  of  No 1	Vere eutopsy findingsyeileble prior to ompletion of cause f deeth?	
a consequence of g in the underlying in the underlying of the of Injury	of): of): of): of): of): of): of): of):	26. Place of her: 4 □ Nursiny et k?	Death (Check oring Home 5 128d. Descri	Did tobacco u  I Ves 2  Wes an eutops performed?  I Ves 2  Inly one)  Residence 6	se contributa I  No 3 Pro  y 24b. W  or  of  No 1  Other (Special Contributa II)	Vere eutopsy finding veileble prior to ompletion of cause f deeth?	
a consequence of a consequence of g in the underlying in the under	of):  of):  of):  of):  DOA Other in the state of the sta	26. Place of ner: 4 □ Nursiny et rk? Yes 2 □ Norme, date and p	23b.  24a. \ Death (Check or ong Home 5 \(\frac{\mathbb{E}}{City or or one}\)  28f. Locati City or one of the total city	Did tobacco u  I Ves 2  Wes an eutops performed?  I Yes 2  II Yes	se contributa I  No 3 Pro  y 24b. We expect of  No 1  Other (Spect occurred	Vere eutopsy finding veileble prior to ompletion of cause f deeth?  Yes 2 No  ify)	
a consequence of a consequence of g in the underlying in the under	of):  of):  of):  of):  DOA Other in the state of the sta	26. Place of Nursing et rk? Yes 2 □ Nome, date and ppinion, death	23b.  24a. \ Death (Check or ong Home 5 \(\frac{\mathbb{E}}{City or or one}\)  28f. Locati City or one of the total city	Did tobacco u  I Ves 2  Wes an eutops performed?  I Yes 2  Residence 6 ibe how injury on (Street and Town, Stete)  the cause(s) e me, date and p	se contributa I  No 3 Pro  y 24b. We expect of  No 1  Other (Spect occurred	Vere eutopsy findings veileble prior to ompletion of cause f deeth?  Yes 2 No  ify)  ral Route Number,  steted. to the cause(s)	
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a consequence of a consequence of g in the underlying in the under	of):  of):  of):  of):  DOA Other in the title in the tit	26. Place of her: 4 Nursiny et rk? Yes 2 No	23b.  24a. \ Death (Check or ong Home 5 \(\frac{\mathbb{E}}{City or or one}\)  28f. Locati City or one of the total city	Did tobacco u  I Ves 2  Wes an eutops performed?  I Ves 2  II Yes	se contributa I  No 3 Pro  y 24b. We expected to the contributa I  Other (Special Contributa I  Number or Run  and manner es a solece, end due to the contributa I  ond manner end	Vere eutopsy finding: veileble prior to ompletion of cause f deeth?  Yes 2 No  ify)  ral Route Number,  steted. to the cause(s)	
	Yrs. Monto  own or Location age City  101.  13. Wes De if Yes. 1 Ye  6a. Decedent's L (Give kind of life. DO NO  Mail C.  9b. Mailing Add 3705 421 of Disposition ( otery, cremetory  Lincoln 22. Name Mail 423 on not enter the in  Arterios	own or Location age City  10f. Zip Code 20  13. Wes Decedent of It if Yes, specify Cub 1 Yes 2 DXNo  6a. Decedent's Usual Occur (Give kind of work done Iffe. Do NOT use retire Mail Clerk  9b. Mailing Address (Street 3705 42nd Ave of Disposition (Name of other), cremetory or other pla  Lincoln Ceme 22. Name and Addre Marshall 4217 9th on not enter the mode of dyin	birthday) Yrs.  If Under 1 Year Months Days Hours  wown or Location  age City  10f. Zip Code 20722  13. Wes Decedent of Hispanic Origin If Yes, specify Cuban, Mentican, If 1 Yes 2 IX No Specify:  6a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Mail Clerk  18. Mother's Ruth  9b. Mailing Address (Street and Number of life, Do NoT use retired)  of Disposition (Name of life, Potential of Life,	age City    101. Zip Code   20722     13. Wes Decedent of Hispanic Origin? (Specify Yes of if Yes, specify Cuban, Mexican, Puerto Rican, etc.   1	birthday) Yrs.   Months   Days   Hours   Min.   B. Date of Birth (Month, Day, Year)   Dec. 30, 19  own or Location  age City    10f. Zip Code   20722   10g. Citize   20722   13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuthan, Mexican, Puerto Flican, etc.)   1	birthday) Yrs.   Months   Days   Hours   Min.   Dec of Birth (Month, Day, Year)   Dec of Birth (Month, Day, Year)   Dec of Birth (Month, Day, Year)   Dec of Disposition (Name of Months)   Days   Hours   Min.   Dec of Birth (Month, Day, Year)   Dec of Disposition (Name of Months)   Days   Hours   Min.   Dec of Birth (Month, Day, Year)   Dec of Birth (Month, Day, Year)   Dec of Disposition (Name of Months)   Dec of Birth (Month, Day, Year)   Dec of Disposition (Name of Months)   Dec of	

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year 9:35 PM April 12, 2000 Marie Bennett English 4a Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth St. Mary's Lexington Park Bayside Care Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) South 5. Sociel Security Number Months Deys 1 M 20 F Yrs. 577-70-2576 72 October 28, 1927 Carolina Usual Rasidance of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No St. Mary's Lexington Park Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21351 Windsor Drive 20653 U.S.A. 14. Race - Amarican Indien. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Black, Whita, etc. 1 ☐ Yes 2 1 No If Yas, Give Year or Dates: 1 ☐ Navar Merried 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homenaker N/A 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Alice Fletcher Willie Bennett 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 21279 Lexwood Court, Lexington Park, Maryland 20653 Ethel English, Daughter 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20e. Method of Disposition M Burial 2 □ Cremation 3 □ Ramoval from State 4 □ Donetion 5 □ Othar (Specify) 21. Signature of Funeral Servica Licansi 22. Name and Address of Facility James E. Vann Funeral Home wor 4804 Georgia Avenue, Washington, DC 20011 6 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one ceusa on each lina. Approximate Intarval Between Onset end Death Tien Immediate Ceusa (Final disease or condition resulting in death) Cardiomyopathy year Dua to (or as a consaguanca ot). Sequantially list conditions, if eny, laeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabeter Mellitus 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? Congertive Heart failure 24a. Wes en eutopsy performed' 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Daath (Check only ona) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 Yes 2NNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Panding investigation 1. Naturel

Examiner The law requires that the death certificate be executed or Attending Physician: efter deeth. Director: After this certifice

attending physician and for use as the burial-trensit P.O. Box 68760, signed by the a Records, been si After this certificate has funeral director, page 2 Division of Vital by the 1

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

2

Examiner

Physiclan/Medical

by

Completed

Be

10

Certification:

edical

State Registrar 2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier (Check only one)

**Funeral** 

Director

with the Marylend

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

29b. Signature end title of certifier Sc baba

6 Could not be determined

29c. Licensa number M. D.

D54346

1 Yes 2 No

29d. Data signad (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama end eddress of person who completed cause of death (Item 23a) (Type, Print)

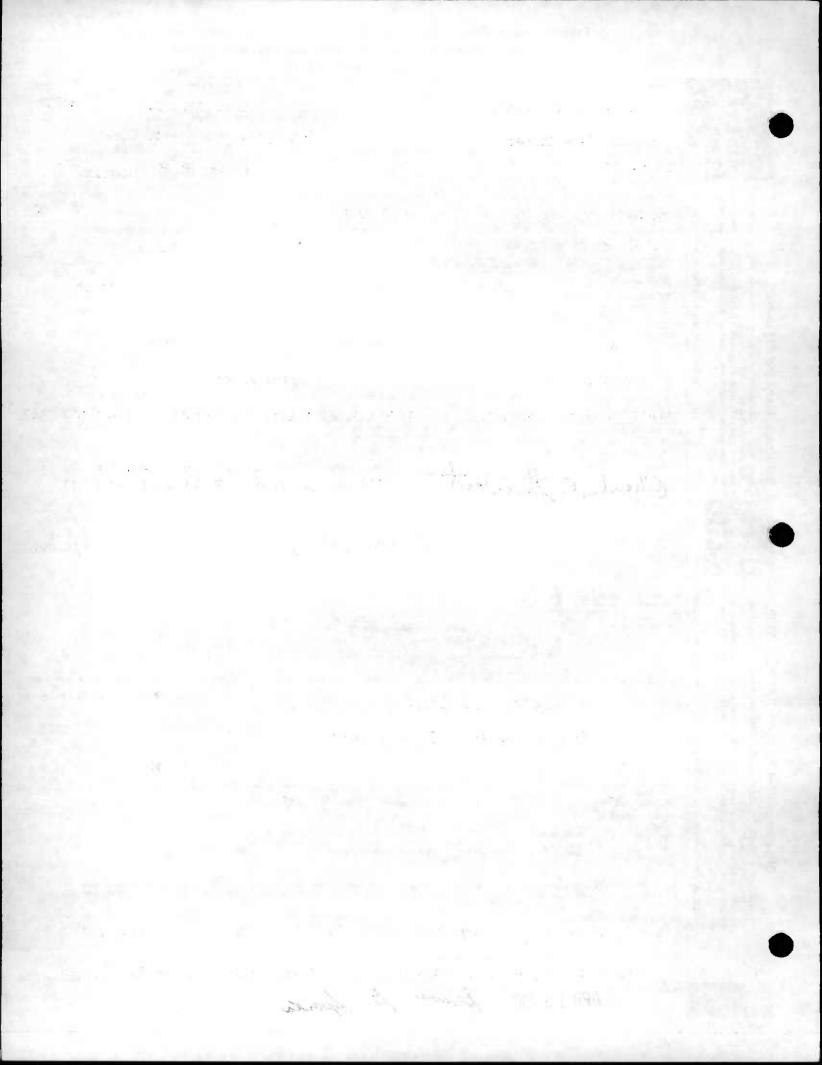
Dr. Chandra Sajja, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636

Certifying Physician: To tha bast of my knowledge, death occurred et the time, date end piece, end due to tha causa(s) and mannar as statad.

 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

APR 1 9 2000 32 32. Registrat's Signature

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month JOHN ROBERT FOUNTAIN 04 19 2000 3:30 PM 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth TALBOT HOSPICE HOUSE TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) FEB. 26, 1910 5. Social Security Number Birthplece (Stete or Foreign Country) MARYLAND 6. Sex. 1☐ M 2☐ F 7. Age (In yrs. last birthday) Months Deys Yrs. 214-32-5157 Usuel Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits TALBOT EASTON tXXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 117 GOLDSBOROUGH STREET 21601 USA

1 ☐ Yes 2XXNo

INVESTOR

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

SPRING HILL CEMETERY

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Fecility

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

18. Mother's Name (First, Middle, Maiden Sumeme)

4-22-00

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.

ANNA MARY TRAX

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

P.O. BOX 135, OXFORD, MD 21654

14 Race - American Indian Black, White, etc.

Specify: WHITE

16b. Kind of Business/Industry

STOCK MARKET

20c. Location - City or Town, State

Approximate Intervel Between Onset end Death

24b. Were eutopsy findings available prior to

completion of ceuse of deeth?

1 Yes 2 No

vr. 2 months

EASTON, MD

illed within 72 hours after a Hygiene. Baltimore, Maryland 21215-0020 permit. Pegas 1 end 2 should be filed v
Depertment of Health end Mentel Hygies important: if itam 27 is marked other th
any injury or other traumatic avant, the pace.

**Physician** 

/Medical

Examiner

10a State

11. Marifal Sfatus

11 Never Merried 2 Married

15. Decedent's Education (Specify only highest grede completed)

FOUNTAIN

ALEXANDER D. FOUNTAIN, JR./NEPHEW

3 Widowed 4 Divorced

Elementery/Secondary (0-12)

ALEXANDER

17. Fether's Neme (First, Middle, Last)

19e. Informent's Name/Reletionship (Type, Print)

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signature of Funerel Service Licensee

20e. Method of Disposition

\*EBurial 2 □ Cremetion 3 □ Removal from State

**Funeral** 

Director

ahow

r 28a-f ahow

0 8 me 23a

0

Director

Funeral

Be Completed by

the Meryland

death

**Physician** /Medical Examiner

ettending physician and I for use es the bunal-trensit The law requires that the death certificate be executed P.O. cate has been signed by page 2 should be detact Records. certificate Division of Vital or Attending Physician: funaral director this After 24 hours after death.

Physician/Medical Examiner à Be Completed Medical Certification: To filled in by

wonam 200 S. HARRISON ST., EASTON, MD 21601 23a. Pent1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Wes en eutopsy performed? 1 Tes 2 1 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOST CE DE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Maturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, streef, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29b. Signature a 29c. License number 29d. Date signed (Month, Dey, Year)

12. Was Decedent Ever in U,S. Armed Forces? 1XXes 2 No If Yes, Give

College (1-4or 5+)

Year or Detes: 1941-1945

State Registrar

31. Date filed (Month, Day, Year)

APR 2 1 2000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID H. SMITH, M.D., 29466 PINTAIL DR. STE 5 EASTON, MD 21601

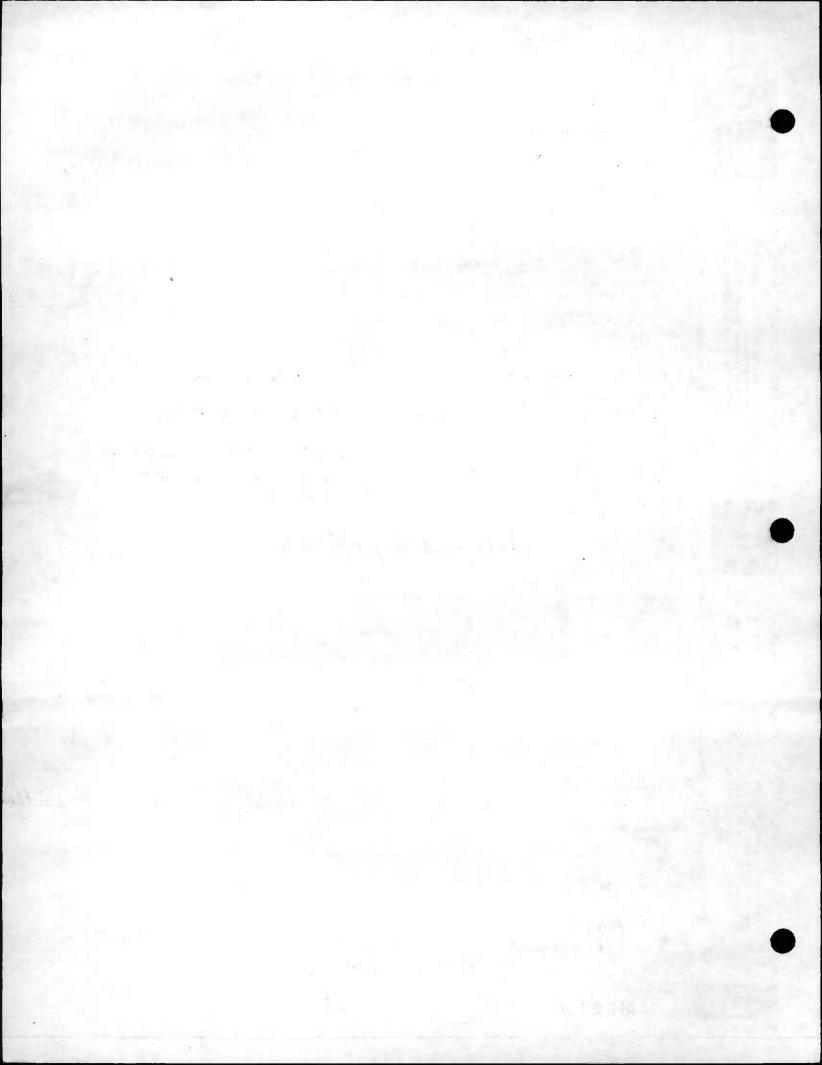
Docks

D39887

**DHMH 16 Rev 6/95** 

Hospital

To the vithin 2



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Joseph 15 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 304N If Under 6. Sax 1 M 2 F 8. Date of Birth (Month, Day) JAN 12, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days Months Hours Country) MAXTON, NC 52 240-80-8236 Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1K Yes 2 No Funeral Director MD PRINCE GEORGES ADELPHI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 2221 HAMPSHIRE DRIVE 20783 UNITED STATES or items 23a filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Coilege (1-4or 5+) 5 t Elementary/Secondary (0-12) permit. Peges 1 and 2 should be filed will Department of Health and Mental Hyglene Important: if Item 27 is marked other trail any injury or other traumatic event, that ponce. POLICE OFFICER DC GOVT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHRISTIAN HENRY FAIRLEY CARRIE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CASSANDRA RUSH FAIRLEY / WIFE 2221 HAMSHIRE DRIVE, ADELPHI, MD 20783 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremetion 3 Removal from State PINEY GROVE METHODIST CEM 4-24-00 MAXTON, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility POPE FUNERAL HOME 11315 LOCKWOOD DRIVE, SILVER SPRING, MD 20904 or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, List only one cause on each line. Approximete Intervel Between Onset end Death 23a. Part 1. Enter the dis shock, or heart fail **Physician** immediate Ceuse (Finat disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner DISEASE Interstition usa es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or trijury that Initieted events resulting in death) Lest Due to (or as a consequence of): Polymyosus Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to tha causa of death? detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cardiomyopathy þ funeral director, page 2 should be 24b. Were autopsy findings aveileble prior to completion of cause of death? Be Completed 24a. Was an autopsy Pulmanary aspergillosis performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Ptece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28c. tnjury et Work? 27. Menger of Deeth 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending 1 Yes 2 No deeth. investigation 2 Accident 3 Suicide

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records. Attending Physician: apital or Attendi nours after deeth. neral Director: A To the Hospital of within 24 hours at To the Funeral D completely filled i

Baltimore, Maryland 21215-0020

6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

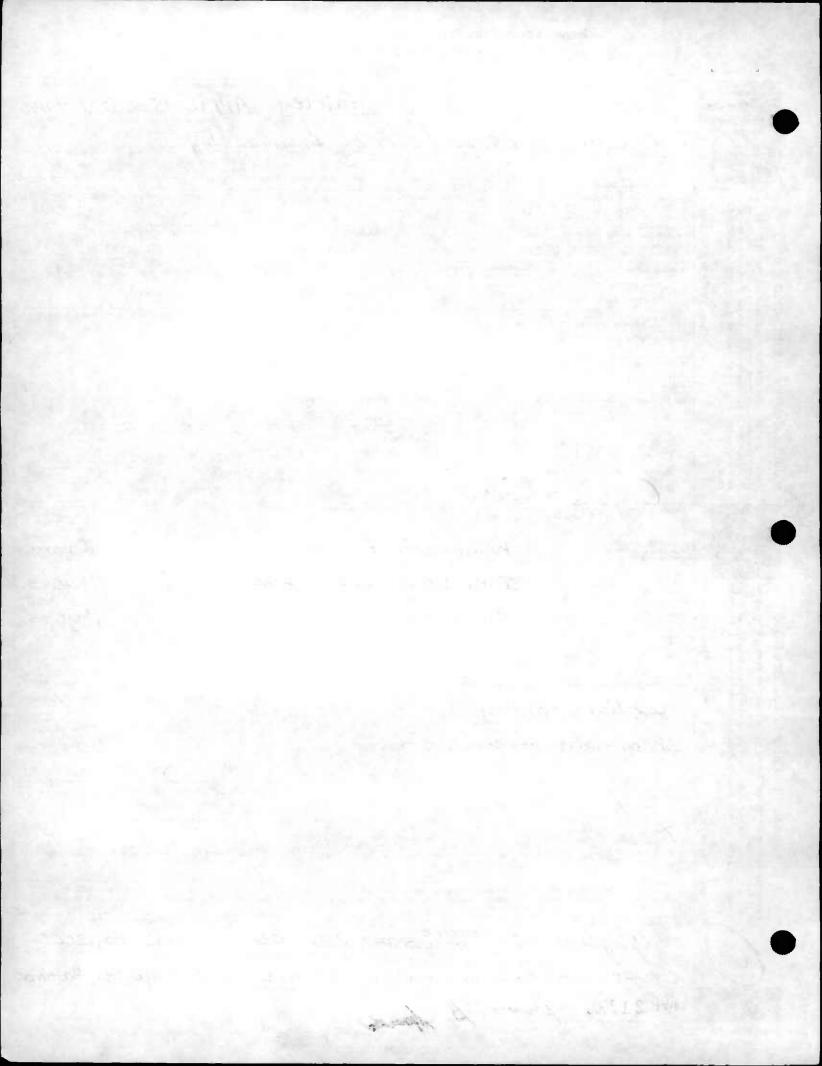
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier MEDIUNE Uglance MD 15, 2000 RES-000 HOUSESTAFF 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPMINS HOSPITAL, 600 N. Wolfe St., Baltimore C. PEART VIGILANCE.

State Registra

edical

APR 2 1 2000

32. Registrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Day April 11, 2000 Walter Burleigh Freeman 8:30 am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Prince George's Hospital Center Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 29, 1914 9. Birthplace (Stata or Foreign Country) New York 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Days Hours 86 Yrs. 079-16-6969 **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince George's Landover Hills Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4405 68th Place 20784 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 N Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Excavator Construction 17. Father's Nama /First Middle Last 18. Mother's Name (First, Middle, Maiden Sumame) Walter B. Freeman Julia Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 5115 South Barnaby Road, Temple Hills, MD 20748 Douglas B. Freeman - Son 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4/12/2000 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) dure of Futueral Service Licenses 22. Nama and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part I. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in death) SEPSIS JINK Due to (or as a consequence of): END STAGE CHRONIC OBSTRUCTIVE PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DISEASE Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stata

Directo

Funeral

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**Funeral** 

Director

be filed within 72 hours after death with the Maryland ntal Hyglene. I other than "naturel", or fleme 23e or 28e-f ehow so orth. The Medical Examiner must be notified at

Comit. Pages 1 and 2 should be file Opperment of Health and Mental Hy important: If item 27 is marked otherny injury or other traumatic avent pages.

21215-0020

Baitlmore, Maryland

P.O. Box 68760,

Records,

Division of Vital

Examiner attanding physicien end for use es the burial-transit or Attanding Physician: The law requires that the death cartificate be executed Physician/Medicai ata has been signed by pege 2 should be detac À Completed certificata After this certifical funeral director, p 8 Certification: To

1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

3717 -

29a. Certifier

Hospital or Attending n 24 hours efter deeth. he Funerel Director; Aft. pletsly filled in by the fur To the Hosp within 24 hor To the Fune completely fi

State Registrar

31. Date filed (Month, Day, Year) APR 1 9 2000

W- SWO

5 Pending investigation

6 ☐ Could not be

38 r

28a. Data of Injury (Month, Day Year)

COTTAGE 32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MARYLAND

D-17874

1 Yas 2 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

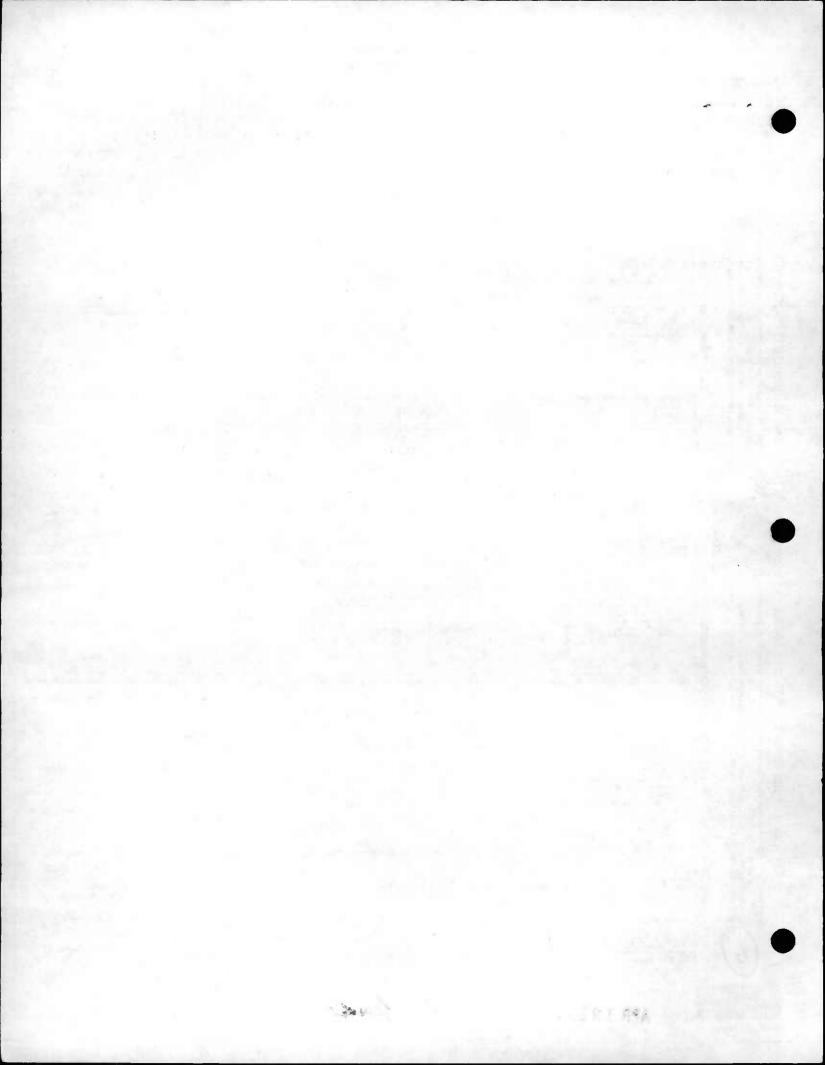
29c. License number

29d. Data signed (Month, Day, Year) April 19, 2000

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANKARAN M: NAYAR ND



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 5 Yaar Month 0633 April Robert Gregory Gentry 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington County Hospital Washington If Under 1 Yaar | If Under 24 Hrs. | 9. Birthplaca (Stata or Foraign Country) West Virginia 5. Social Security Number 8. Data of Birth (Month, Day, Year) Sept. 7, 1923 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 □ F Yrs 235-28-8349 76 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 USA 4 Oak Tree Lane Apt. E 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 N Married If Yes, Giva Year or Datas: WW | | 1 ☐ Yas 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 6 Area Manager Utility Company 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Joe Gregory Gentry Jessie Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 4 Oak Tree Lane Apt. E Williamsport, Maryland 21795 Janet M. Gentry/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 6 Other (Specify) 4-26-00 Smithsburg, Maryland Smithsburg Crematory 21. Signature of Fur ral Service Licer deborne and Address of Fasility Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) metabolic acidosis Due to (or as a consequence clelerium Tremens Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical 26. Place of Death (Check only ona) Hospital: 12 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 25 No

**Physician** /Medical Examiner

permit. Pages 1 end 2 should be filed within 7. Department of Health and Meniel Hyglena. Important: if item 27 is marked other than "na any injury or other traumatic event, the Media page.

Physician

/Medical

Examiner

**Funeral** 

Director

"natural", or flama 23a or 28a-f show

filed within 72 hours after death with

21215-0020

Baitimore, Maryland

Director

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Completed

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physician a the burta certificate 2

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à Completed Be Certification: To

Attending after death Director: 8 24 hours at Funeral Di letely filled in Within 2 To the F

Division

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adical

31. Data filed (Month, Day, Year) APR 2 6 2000

27. Magner of Death

Natural 2 Accident

3 Suicide

29a. Certifier

29b. Signatu

4 Homicide

5 Pending investigation

6 Could not be detarmined

ewman

no completed cause of death (Item 23a) (Type, Print) 11110 med a

28a. Data of Injury (Month, Day Year)

32. Registrar's Signatura

28b. Time of

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work?

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yas 2 No

On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

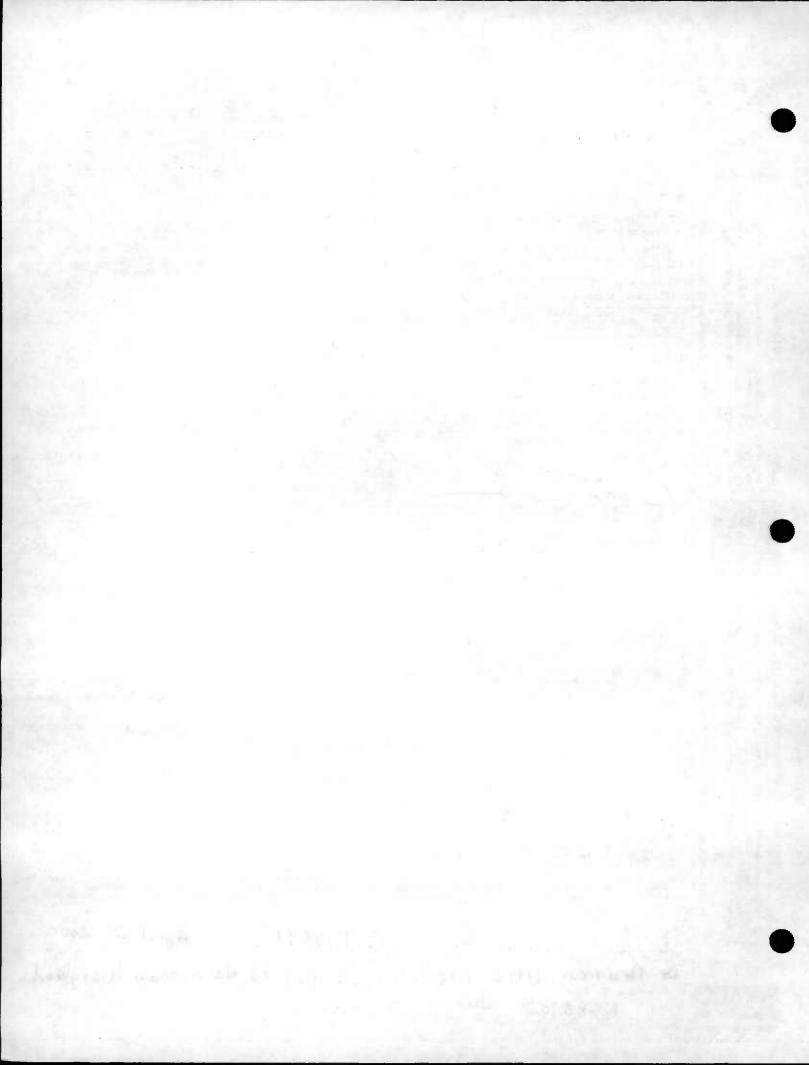
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

April

Rd Hagerstown

29d. Data signed (Month, Day, Year) 26

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Nora Marie Gaughan April 22, 2000 7:15 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 1011 Carson Drive Huntingtown
If Under 24 Hrs. 8. Date Calvert If Under 1 Year 5. Social Security Number 8. Data of Birth Feb. 16,1928 Birthplaca (State or Foreign Country)
 New York 6 Sax 7. Age (In vrs. last birthday) Days 1 M 2 M 72 Yrs. 122-22-6446 Usual Rasidenca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 ☐ No Huntingtown Maryland Calvert 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1011 Carson Drive 20639 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxican, Puarto Rican, atc.)

★★

1 □ Yes 2 □ Ns Specify: 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yes, Give Yaar or Detes: 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 A.T. & T. Tele-Communications Operator 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Patrick Joseph Gaughan Sarah Agnes Mangan 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Carson Drive Huntingtown, Maryland 20639 Sharon L. Candore (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2☐ Cramation 3 ☐ Removal from Stata April 4 □ Donation 5 □ Other (Specify) Lee Crematory Clinton, Maryland 24, 2000 21. Signature of Dineral Stante Licens 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland BLVD. Owings, MD 20736 Ry 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta intervel Between Onset and Death Immediata Cause (Final disease or condition resulting in death) CANCER LUNG Due to (or es a consequence of): Sequentially list conditions, if any, teading to immediata cause. Entar Underlying Cause (Disease or injury that influed events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY DISEASE 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yas 2 No 1 □ Yas 2 □ No 25. Wes casa referred to medical axaminer? 26. Placa of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records.

Division of Vital

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or itema 23a or 28a-1 show eny injury or other traumatic event, the Medical Examine must be notified all publics.

Physician/Medical Examiner þ Be Completed

Medical Certification: To

attending physician and for use as the burial-transit signed t

The law requires that the death certificate be executed this cartificate To the Hospital or Attending Physicien: Within 24 hours after death.

To the Funerel Director: After this cartifica completely filled in by the funeral director, p.

State Registrar

29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred et the time, data and place, and dua to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the tima, date end place, and due to the cause(s) and manner stated. 29b. Signatura artit titta of certifier

5 Pending

investigation

6 ☐ Could not be datarmined

1 Yas 2 No

27. Manner of Deeth

Natural

2 Accident

3 ☐ Suicida

4 Homicide

28a. Dete of Injury (Month, Day Year)

29c. Licensa number D40370

28c. Injury at Work?

1 Yas 2 No

29d. Date signed (Month, Day, Year) 2000

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

28d. Describe how injury occurred

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

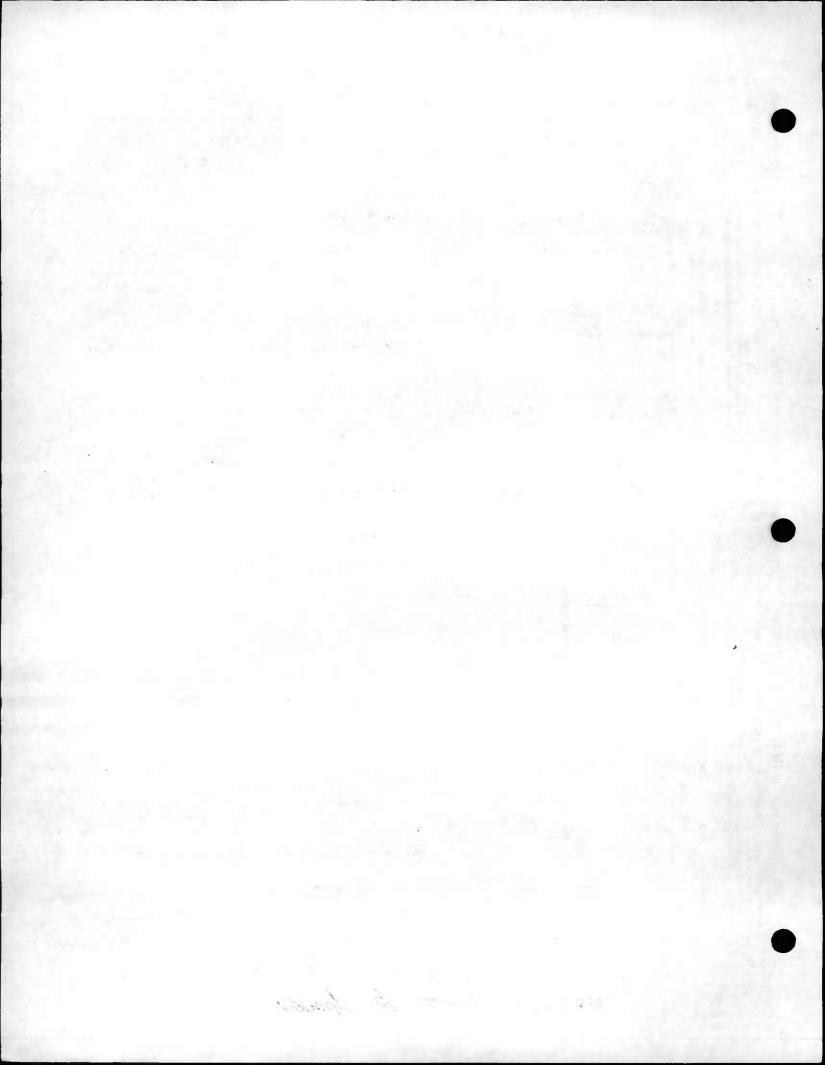
Peter Wisniewski, M.D. Prince Frederick, Maryland 20678

Hospitet: 1 | Inpatient 2 | ER/Outpatient 3 | DOA

28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

31. Data filed (Month, Day, Year) 32. Registra/s Signetura APR 2 5 2000 \



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** GRACE RUSSELL GALE APRIL 2000 10:40PM 14 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 718 MAIN STREET SHARPTOWN WICOMICO 5. Social Security Number 7. Age (In vrs. lest birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MARYLAND **Funeral** Hours 1□M 2XF Months Deys 217-28-4618 70 Director FEB. 3, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits od other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 No Yes 2 No Director MARYLAND WICOMICO SHARPTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 718 MAIN STREET 21861 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11 OWN HOME paemil. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If New 27 is marked other any injury or other traumatic event ance. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be JOHN EDWARD RUSSELL 2 MARY ELIZABETH GRAVENOR 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) GEORGE C. GALE/HUSBAND P. O. BOX 443, SHARPTOWN, MARYLAND 21861 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) SPRINGHILL MEMORY GARDENS 4/18/00 HEBRON, MARYLAND 22. Neme end Address of Facility
ZELLER FUNERAL HOME, P. O. BOX 207, fal Service Licer 106 MAIN STREET, EAST NEW MARKET, MD 21631 inplications that plused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, **Physician** Immediate Ceuse (Final disease or condition resulting in death) Metostatic /Medical Concer Examiner Due to (or es e consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In death) Last Due to (or es e consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? page 2 should Be Completed 24a. Wes en eutopsy certificate has 1 □ Yes 2 ☑ No 1 Tyes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဥ 1 ☐ Yes 27. Manner of Death 28e. Date of Injury (Month, Dey Yeer) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner stated. 29a. Certifier one) 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Yeer)

DaGATE

Salish MO

State Registrar 30 Name end eddress of person

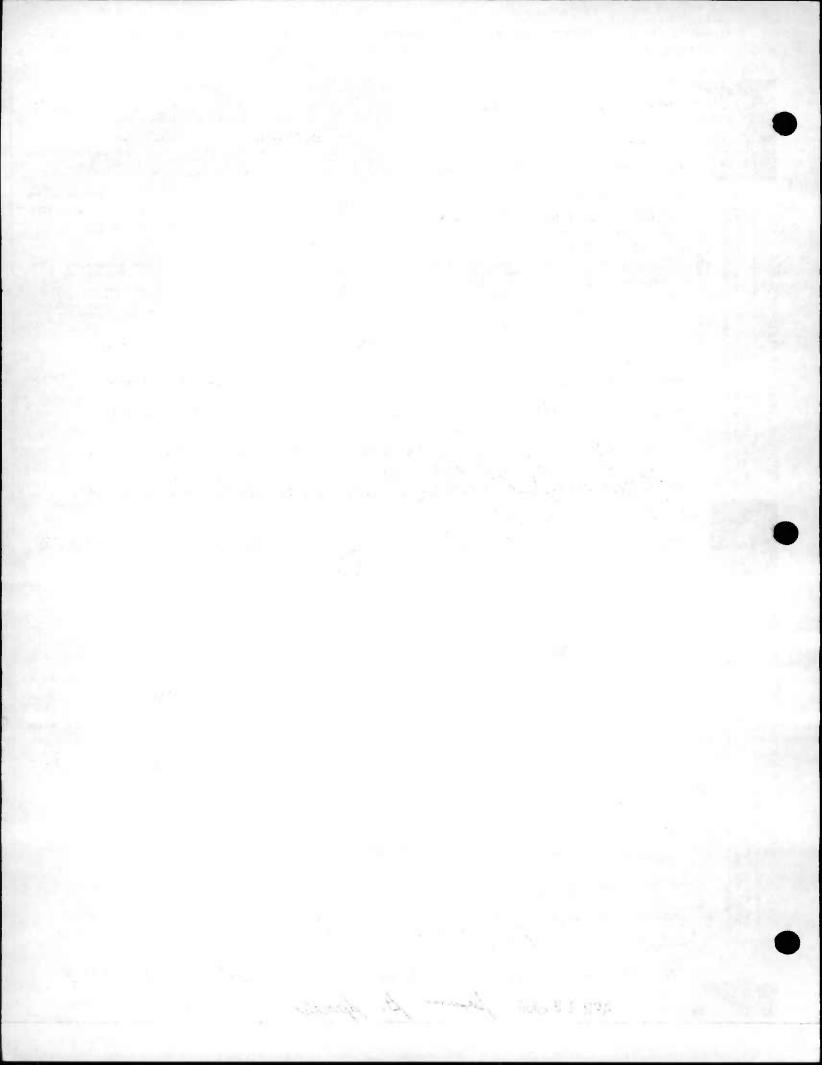
31. Date filed (Month, Day, Yeer)

who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

MO

145E.



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year FRANCES MARGARET GRUNDEN April 18 2000 4:30 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Genesis ElderCare Easton Talbot The If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULYI, 1912 9. Birthplaca (State or Foreign 1 M 2 F Days Yrs. MARYLAND 216-40-4430 Usual Residence of Decedant 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD TALBOT EASTON 14 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHMANS LANE 21601 USA 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER OPERATOR SEAFOOD MARKET 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) THOMAS P. GAY BERTHA PATRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) HARRY W. GRUNDEN/SON 27903 HALEY ROAD, EASTON, MD 21601 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 4-20-00 EASTON, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral ervice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, P.A. 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death Stem CVA Immediata Causa (Final disease or condition resulting in death) ZWeek middle Celrof ark Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying ceuse given in Part i. 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of daath? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese raferrad to medicel examiner? 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatienf 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Examiner physician end s the burial-transit The law requires that the death certificate be asscuted P.O. Box 68760. signed b Records,

certificate

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After

Hospital

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Division of Vitai or Attending Physician: **Physician** 

/Medical

**Examiner** 

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**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hyglene.
It learn 27 is ratived other than "natural, or its uny or other traumels event, the Medical Examines uny or other traumels event, the Medical Examines.

important: Il any injury o

**Physician** 

/Medical

Department

Frances Grunden Baltimore, Maryland 21215-0020

Physician/Medical Examiner þ Completed Be

page 2 Juneral director Medical Certification: To n 24 hours after death.

The Funeral Director: After the lure of t completely filled in

Natural 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

 Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier (Check only one)

Mood

29c. License number 1788715 29d. Date/signed (Month, Day, Year) 19/00

30. Nama and addrass of person who completed ceuse of death (flem 23a) (Type, Prinf)

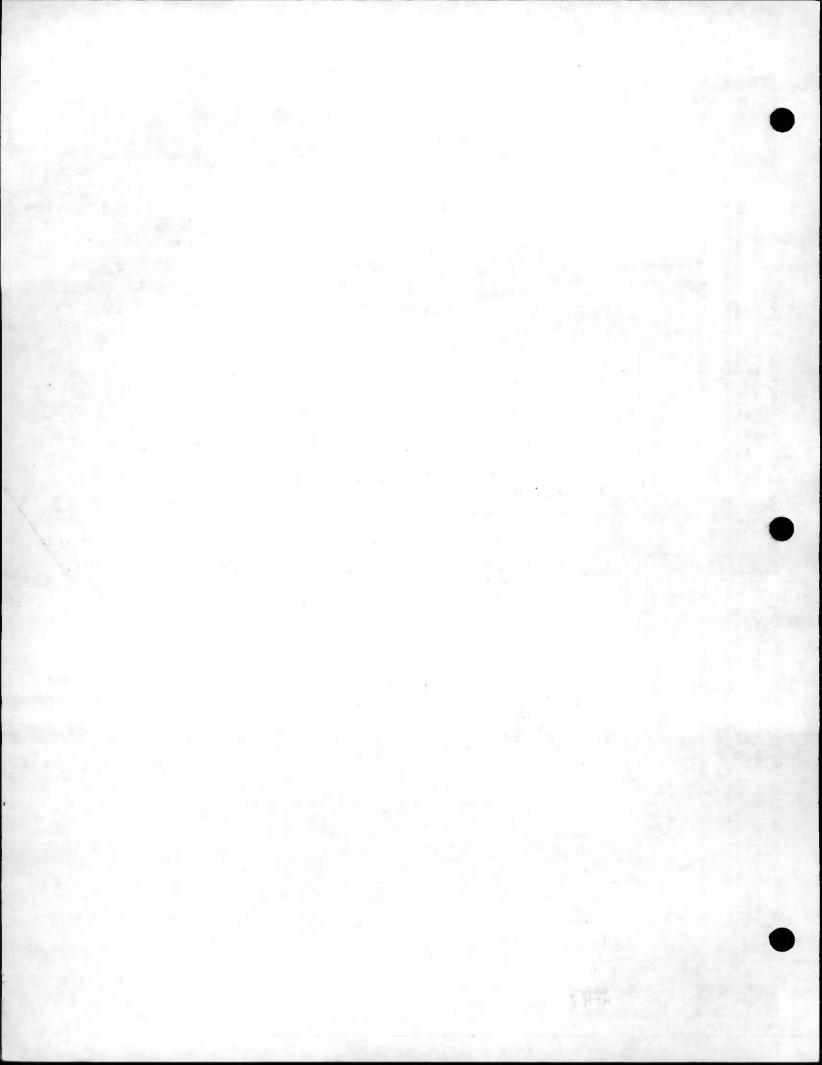
william H. WOOD, JR., M.D. 505 IDLEWOOD AVENUE, EASTON, MD 21601

State Registrar



am

32. Registrar's Signature



Please Type or Print in Black Indeible Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** PAULE GRAYBEAL 2000 4b. City, Town, or Location of Death 13:05 /Medical 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE
IT Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 □ F 80 Yrs. MAY 31, 215-18-3035 1919 Director NC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any lylury or other traumatic avant, the Macinal Enant vier must be notified at one. 1 Yes 2 No Director MARYLAND TALBOT EASTON 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 7085 OLD SCHOOL HOUSE LANE 21601 II.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: 11 Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Rusiness/Industry Elementery/Secondery (0-12) College (1-4or 5+) CHEMICAL ENGINEER SPECIALTY CHEMICALS 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GLENN H. GRAYBEAL CORA WELLS 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) EVELYN M. GRAYBEAL / WIFE 7085 OLD SCHOOL HOUSE LANE EASTON, MARYLAND 21601 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) CREMATION CTR CHES. 4-17-00 CHESTER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME Newnarm 200 S. HARRISON ST., EASTON, MD. 21601 23a. Pert. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximate tntervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical DIFFUSE PULMONARY HEMORRHAGE Examiner Due to (or es e consequence of): Physician/Medical Examiner WEGENER'S GRANULOMATOSIS attending physician and for use as the bunel-transit certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): thet initieted events resulting in death) Lest Due to (or es e consequence of) The law requires that the death Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown signed to ò 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy page 2 1 ☐ Yes 2 ŒNo 1 ☐ Yes 2 1 No certificate or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending Investigation 1 Neturel 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 2 filled 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medical completely (Check only one) To the To the To the F 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year)

State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

68760

Box

P.O.

Records,

Division of Vital

810 South Milten Avenue

32. Registrar's Signature

P13408

April 14, 2000

Baltimer, Maryland 21224

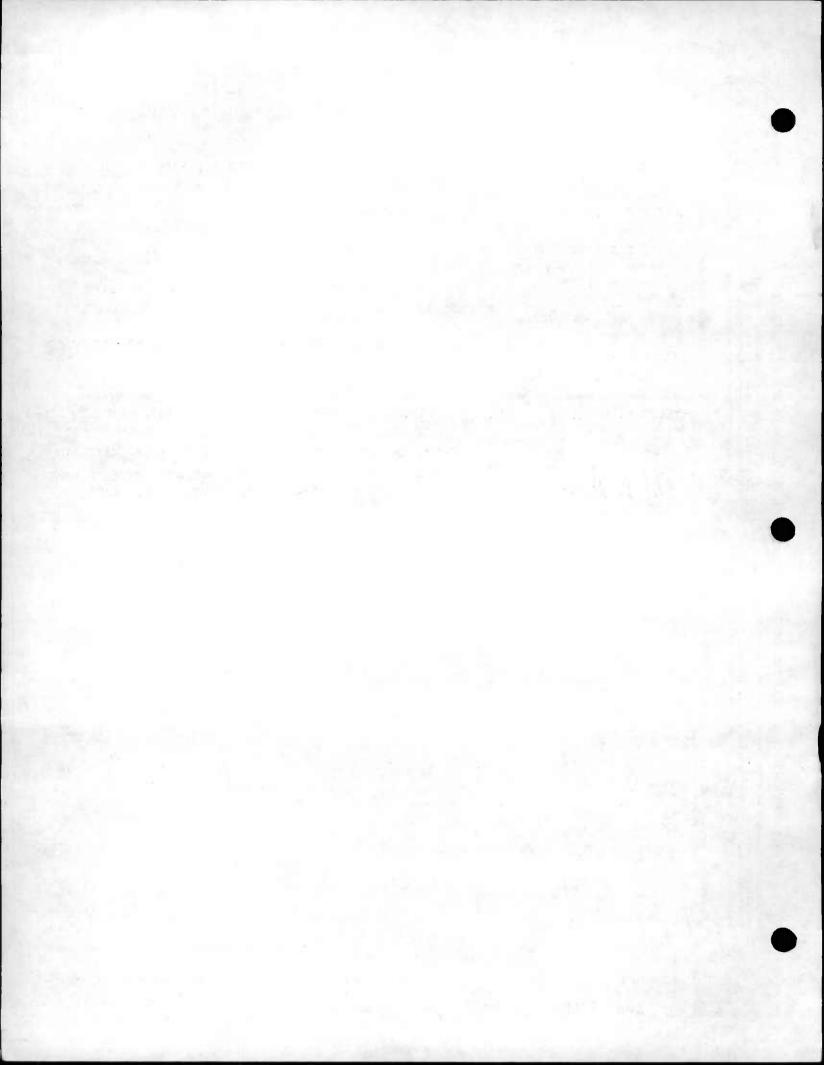
Roberto Scaffed , MD 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

Roberto Scaffidi

7 2000

31. Dete filed (Month, Dey, Year)

APR 1



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 0940 Year 21 2000 MAE HUTZELL ELLA Dri 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. JULY 17, 1923 Birthplaca (Stata or Foraign Country) MARYLAND 5. Social Security Number 1 M 2 X F 220-42-5536 Usual Rasidence of Decedent 10a, Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yas 2 □ No **BOONSBORO** MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 U.S.A. 101 VALLEY VIEW COURT 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or Nottl Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify 3 ☐ Widowed 4 P Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SHOE MANUFACTURING 9 EYELETER 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) MARGARET MINERVA VINSON FRANK (UMN) HENNINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY S. MOSER/DAUGHTER 101 VALLEY VIEW COURT, BOONSBORO, MARYLAND 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 2 Burial 2 ☐ Cremation 3 ☐ Removal Irom Stata 4 Donation 5 Dother (Specify) 4/25/00 BOONSBORO, MARYLAND BOONSBORO CEMETERY ature of Funeral Service Co 22. Name and Addrass of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Daath Breast Cancer Immediata Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Kenal Failure 1 Yes 2 No 3 Probably 4 Unknown nypeardial infanction 24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 5000 1 ☐ Yas 2 ☐ No 25. Was cose referred to medical axaminer? 26. Placa of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify) 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation

P.O. Box 68760, been signed by the a should be detached ( Records, cartificata Division of Vital Attending Physician: this deeth. 24 hours after deeth • Funerei Director: A pletely filled in by the f ŏ

þ Completed Be

edical

Physician/Medical Examiner Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23s or 28s-f show

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pernit. Pages 1 end 2 should be filed within Department of Health and Mentel hygiene. Important: if Itam 27 is marked other than "neny injury or other traumatic event, the Market in Italians or other traumatic event, the Market in Italians in Ita

**Physician** 

/Medical

Examiner

72 hours after death

Maryland 21215-0020

Director

Funeral

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Completed

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27. Manner of Death 1 Savatural 2 Accident

3 Suicide 4 ☐ Homicide

(Check only one)

29a. Certifier

6 Could not be

28e. Place of Injury - At homa, larm, street, lactory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signatura and title of certifier win

29c. License number

1 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) April 21, 2000,

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

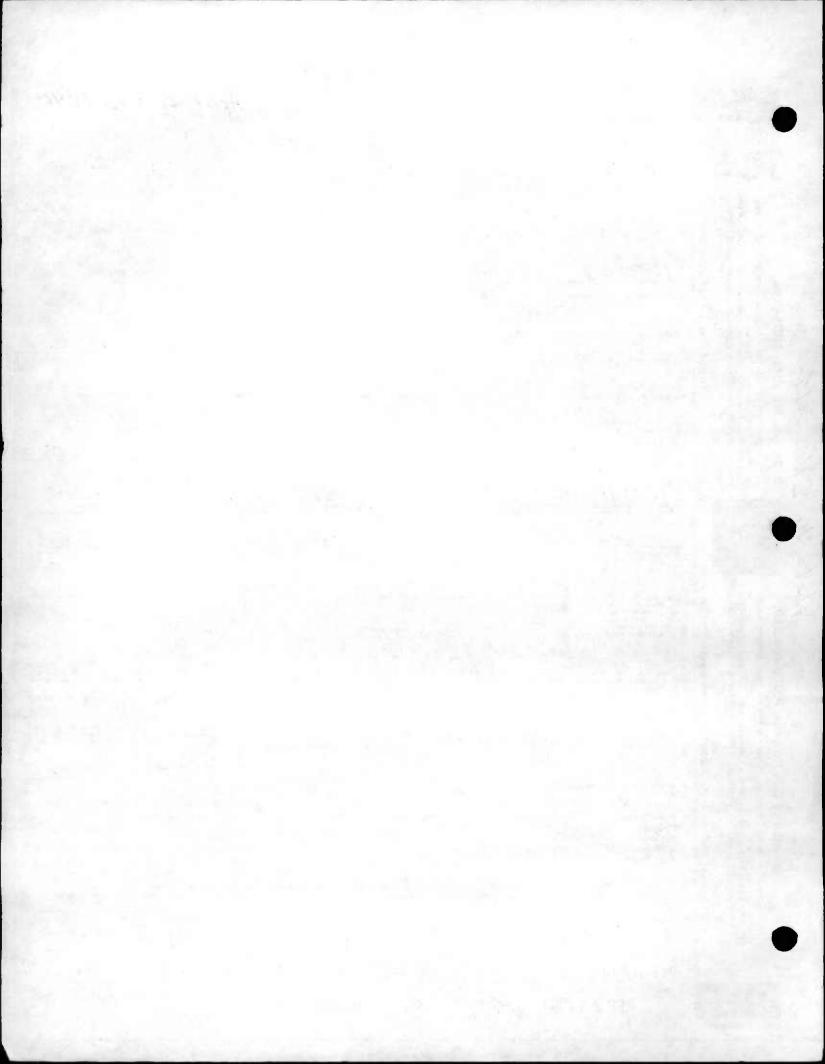
Zafav Malle 31. Date fijled (Month, Day, Year) APR 2 4 2000 20 311 Laphans Rel

Boonsloono, MD 2/7/3

Registrar

Hospital

To the Hosp within 24 hor To the Fune completely fi



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien n Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Emma Oyeman Hensel 22 April 2000 00:25 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) Months 10M 20F Yrs. 212 09 3004 April 6 1915 Maryland Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Lusby 1 ☐ Yes 🎾 ☐ No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1829 Tonque Cove Road 20657 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking bookkeeper 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) George F.C. Oyeman Katherine M. Fricke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Harry A. Hensel, Jr.- husband P.O. Box 361 Solomons, Maryland 20688 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Metrolitan Funeral Service 23 2000 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Stata Alexandria Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 of enter the mode of dying, such as cardiac or respiratory arrast. 23a. Part1. Enter the disease, or complications that caused the death. Do not exhock, or heart tailure. List only one cause on each line. Intervel Between Onset and Death

**Physician** /Medical Examiner

Physician/Medical Examiner

ettending physicien end for use as the burlai-transit

signed by i

The law requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vitai

Hospital or Attending Physician:

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after deatl Director:

To the Hospital of within 24 hours at To the Funeral D completely filled is

this funeral

After

**Physician** 

/Medical

Examiner

Director

Completed

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10a. Stata

**Funeral** 

Director

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"natural", or items

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Introportant: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Europages.

Saltimore, Maryland 21215-0020

Immediata Causa (Finel disease or condition resulting in death) Metastatic Melanoma Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as e consequence of): that initiated events rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease þ Completed Chronic Obstructive airway disease 25. Was casa referred to medical B Other: 4 Nursing Hom Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1	23b. Did tobacco use co	ntribute to the c	ause of death?
	1 ☐ Yes 2 ☐ No	3 Probably	<b>★</b> □ Unknown
-	24a. Was an autopsy performed?	24b. Ware au available completi of death?	prior to
	1 ☐ Yas 2 ☐ No	1 ☐ Yas	2 No

more than 2

months

	1 Yas	2₩ No
27.	Manner of	Death
	1 ₩Natur	al 5
	2 Accid	lent
	3 Suici	de 6
	4 Homi	icide

Pending investigetion Could not be determined 28a. Deta of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 TYes 2 No 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and plece, end dua to the cause(s) end menner es stated.

2 Medical Examiner: On the best of examinetion end/or invastigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner steted.

29b. Signatura and title of certifier an and gu

29c. License number D50653

29d. Data signed (Month, Day, Year) April 22, 2000

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

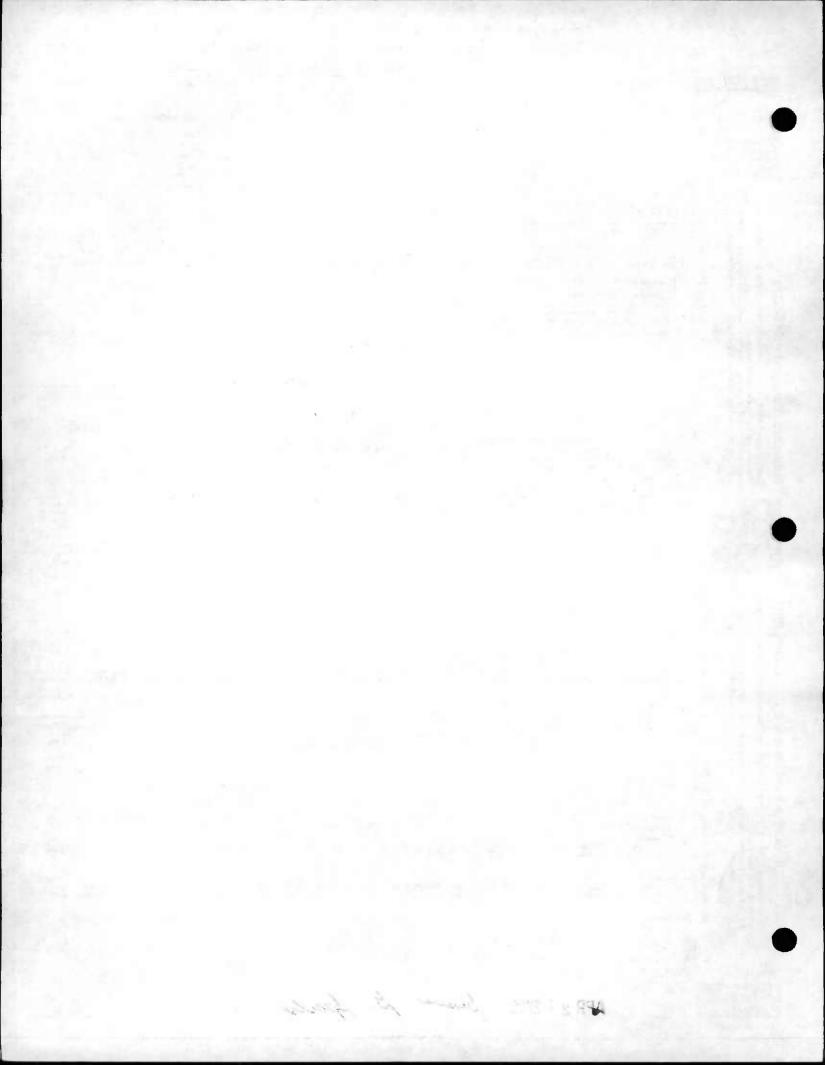
GYAN SURANA, M.D. DEALE, MD. 20751

APR 2 4 2000 \

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** ELLIS MAYLAND JONES 8 2000 APRIL /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Dey, Year) Aug. 8, 1921 **Funeral** 18 M 2□ F Deys 219-05-2013 78 Yrs. Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hyglene.
other than "natural", or frame 23a or 28a-f ahow vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Hagerstown Washington County 1⊠ Yes 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Blue Spruce Circle 21740 U.S.A. Funeral 14. Race - American Indien, Black, White, etc. 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2 ☐ No If Yes, Give 9 Year or Dates: 2 1 Never Married 2 Married 11/42 1 ☐ Yes 2 No Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufacturino Tool Planner 12 permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygles Important: if item 27 is marked other th any injury or other traumatic event, ITS PRICE. 0 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Edgar Jones Mary Landers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) H. MaRea Sally Jones/Wife 15 Blue Spruce Circle, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Smithsburg Crematory Apr.21 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Douglas A. Fiery Funeral Home 23 Part Enter the disease or complications that cassed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) METASTATIC COLON CAPCINOMA that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown tor: After this certificate has been signed the funaral director, page 2 should be de ð 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1. ENatural death. 1 Yes 2 No To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. Medical 29a, Certifier

State Registrar

**DHMH 16 Rev 6/95** 

21215-0020

Baltimore, Maryland

Box 68760.

Division

APR 2 0 2000

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

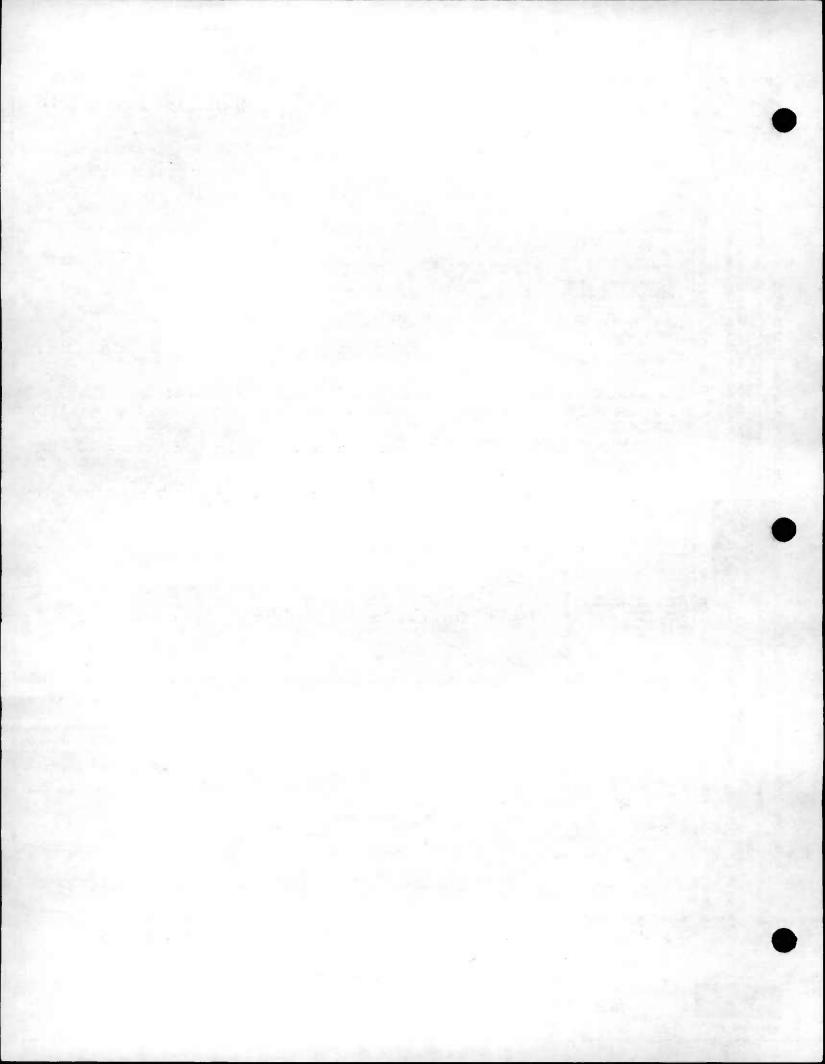
Weenberg

32. Registrar's Signature

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year) 04-19-00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Year LILLIAN ARDENIA KINSEY 2000 April 14 0107 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1□M 2 F Yrs. Director 228-22-6256 July 16 1926 Virginia Usual Residence of Decedant 10a, Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Dorchester Fishing Creek 10e. Streat and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filled within 72 hours after death with a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "... any injury or other traumatic other than "... 2535 Old House Point Rd. 21634 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Navar Married 2 Merried 1 Yas 2 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 8 homemaker own home 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Samuel Bateman Lillian Campbell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Walter E. Kinsey-husband 2535 Old House Point Rd, Fishing Creek, MD 20a. Mathod of Disposition

1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stata 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cemetery 4/17 Hurlock MD 21. Signature of Ednaral Sarvice Licensee Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one cause on sech line. Approximete Interval Between Onset end Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Sepsis 11 hours Examiner Dua to (or as e consequence of): Physician/Medical Examiner Pneumonia 6 days use as the bunal-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants and Dua to (or es e consequence of): P.O. Box 68760, attanding physician c Congestive Heart Failure
Dua to (or es e consequence of): rasulting in death) Last jo Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Myocardial Injury signed t Records, 2 24b. Were eutopsy findings eveilable prior to completion of cause of death? director, page 2 should Be Completed 24a. Wes an eutopsy performed? peen 1 Yes 2 No certificate 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 Xinpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To 2 ER/Outpatient 3 DOA this funerai 27. Mannar of Death 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred After 1 Natural 5 Pending invastigation death. 1 Yes 2 No To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifian (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 50328 2000 30. Neither and eddress of person who complated cause of deeth (Item 23a) (Type, Print) MD 219 S. Washington St. Easton, MD 21601 James Elmore, 32. Registrar's Signature 31. Data filed (Month, Dey, Year) State APR 1 9 2000 Registrar

APR 182000 James & Morris

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	1. Decedent's Name (First, Middle, Last)	2. Dete of Dea	th	3. Time of Death
ician	Raino Karjalainen	Month April	Dey 13, 2000	
dical niner	4a Fecility Name (If not institution, give street and number)  4b. City, Town, or		4c. County of De	-
iller	3603 63rd Avenue Landover			George's
al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.			tirthplece (Steta or Foraign Country)
or	008-09-8711	October	31, 1916 Ma	assachusetts
	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
oto	Maryland Prince George's Landover			1 ☐ Yes 2 No
Olre	10e. Street and Number 10f. Zip Code	1	log. Citizen of What	Country?
10	3603 63rd Avenue 20785		U.S.A.	
by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerl Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl Yes, Give Year or Dates:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Bleck, WI Specify: W	
010	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)	kina	16b. Kind of Busines	
Completed	Elementary/Secondary (0-12)   College (1-4or 5+)		Self-Empl	•
Š	9 Mechanical Contractor			tioning Ind.
89			Maidan Sumame)	
0	,	Unavaila	,	
	19a. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			, Zip Code)
	Kenneth B. Karjalainen - Son P.O. Box 54, Barstow,			
	20a. Method of Disposition  1  Burial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify)  20b. Place of Disposition (Nama of cemetery, cremetory or other place)  Resurrection Cemetery  22. Name and Address of Fecility	4/18/2000	20c. Location - City of Clinton, N	
1	21. Signature of Furnital Service Decease  22. Name and Address of Fecility Gasch's Funeral H 4739 Baltimore Av  23a. Part 1. Enter the disease or combinations that caused the distant. Do not antar the mode of dying, such as cardiac shock, or heart fallure. List only one cause on each line.	enue, Hy	attsville	Approximate Intervet Batween Onsat and Daath
liner	disease or condition resulting in death)  e. Due to (or as a consequence of the condition o	Jour	eran	years
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			years
/Medic	that initiated events resulting in death) Last  Due to (or as a consequence of):  d. Oldwrid rundernyppe	they		years
clar		V		
by Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.			Probably 4 American
Completed b	anemia	24a. Wes e		o. Were autopsy findings eveilable prior to completion of cause of daath?
5		1 🗆 Y	es 2 No	1 ☐ Yes 2 ☐ No
200	25. Was case referred to medical 26. Place of Dec	eth (Check only or	16)	
	examiner? Hospitel: Other	1	ance 6 Other (S)	pecify)
Certification: 1	27. Manney Death  1 12 Telephone    1 12 Telepho	28f. Location (S	ow injury occurred	Rurel Route Number,
	4 Homicide building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place	City or Tow		as stated.
edical	(Check only anni)  2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurrent anni)	rred at tha tima, d	lata and place, and d	ua to the causa(s)
ž	29b. Signature and title of certifier 22 29c. License number		9d. Date signed (Mo	onth, Dey, Year)
	> James Waffeerding WD DO 5401		April 14,	2000
	30. Name and eddress of person who completed cause of defin (Item 23a) (Type, Print)  James W. Harding, M.D. 7525 Greenway Center Drive #3  31. Date filed (Month, Day Year)	16, Gree	nbelt, MD	20770-3525
tate strar	APR 1 9 2000 32. Registrar's Signatura			

Marine Samuel

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) gate of Death 18,2000 Month Physician March /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give/street and number) Examiner Altimore topkins Hospital ohns If Under 1 Ye If Under 24 Hrs. 6. Sal 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 10 M 20 F Vrs unknown Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Inportant: If the Aleith and Meniel Hygene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show eny injury or other traumatic event, the Madical Examiner must be notified an able. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Ose Da 12 Yas 2 No Completed by Funeral Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 123 1090 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1□ Yes 2DHNo Specify 1ac 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1A NA 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidea Sumeme) 8 Holland 19a, Informant's I me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) mother 04 We osedale 2/23 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, cremetory or other p 20c. Location City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Disposal 22. Name and Address of Facility nature of Funeral Service Licens 600 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) minute xtreme Examiner Physician/Medical Examiner Term abor or Attending Physician: The lew requires that the death certificate be executed attending physicien end for use as the burlei-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Wara autopsy findings available prior to completion of cause of death? funerel director, page 2 ahould Be Completed 24a. Was an autopsy performed? After this certificate has 2 No 1 Yas 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA Unnationt Marther of Di Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: Afte completely filled in by the fun 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signat 29c. License number 29d. Data signed (Month, Day, Year)

Registrar **DHMH 16 Rev 6/95** 

State

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31. Date filed (Month, Day, Year) MAY 0 5 2000

Wolfe

se of death (Item 23a) (Type, Print)

paltimore, Maryland

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		XIII VALLED III	Certificate of De	ath	Reg. No.	14598
Physician	1. Decedent's Name (First, Middle,			2. Dete of De Month	Dev Y	a. Time of Deeth
/Medical	4e Fecility Neme (If not institution,	give street end number)	111	ity, Town, or Location of Deat	100	000 6:37 Deeth
Examiner	THE THAN	5 HORINS	HOSPITAL BA	UTIMERE CLT	3/	
uneral	5. Social Security Number	6. Sex 7. Age (In yrs	lest birthdey) If Under 1 Year If	Under 24 Hrs. 8. Date of Bir lours Min. (Month, D	th g	Birthplace (State or Fore
irector	unknown	10 M 20 F	Yrs.	1 4-0	5-00	mo
<b>8</b> = <b>8</b>	Usuel Residence of Decedent  10a. State 10b. County	10c. Ç	ity, Town or Location			10d. Inside City Lim
28a-f shown noutlised at	mD	13	altimore			1 X Yes 2 □
r from 23a or 28a-1 a ciner must be notified Funeral Director	10e. Street end Number	1 ^	10f. Zip Code		10g. Citizen of Who	et Country?
23a 182	2410 Lle	welyn AL	le 2/2	13	u:	317
herra mer ma	11. Mantal Status  1 Never Merried 2 Merrie	12. Was Decedent Ever in t Armed Forces?	J.S. 13. Was Decedent of Hispe If Yes, specify Cuben, N	nic Origin? (Specify Yes or No lexicen, Puerto Rican, etc.)	Hace - Black,	American Indian, White, etc.
· ·		ed 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 □ Yes 2 □ No S	pecify:	Specify:	Blank
		s Education	16e. Decedent's Usual Occupation (Give kind of work done durin	n most of working	16b. Kind of Busi	ness/Industry
	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	ig most of working	. )	/ -
Con Fig.	17. Father's Name (First, Middle, L	NIA	NA	Mother's Neme (First, Middle	Maiden Sumema	A
c ever		as only		otania	6110	111
7 is marked other ther traumatic event, the A To Be Comp	19e. Informent's Neme/Relationsh	ip (Type, Print);	19b. Mailing Address (Street and	Number or Rural Route Numb	er, City or Town, St	ete, Zip Code)
27 is	Latonya Lu	ndu/mother	-2410 LLewe	Ivn Ave-Be	ilto. Mo	1.2/2/3
if item 27 i or other tra	20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion		Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - Ci	ty or Town, Stete
mportant: Indiany o	4 □ Donation 5 □ Other (Sp	ecity) Disposal Jo	has Hopkins Hos	pital 42600	(Balto.	mp.
mportant: any injury c	21. Signeture of Funeral Service L	icensee	22. Neme end Address d		~ .	6
240	Debora	h Evans	DHH-600		St - 6	
	23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the dee only one cause on each line.	th. Do not enter the mode of dying, s	uch es cardiac or respiretory e	rrest,	Approximate Intervel Between Onset end Deati
sician edical	Immediate Cause (Final	5	O. his			204/7 wee
miner	disease or condition resulting in death)		e Prematurity	/		2011100
ne ne	1.00					
60		Due to (	or es e consequence of):			
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ician end burial-trensit	Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	с				
he bur	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest	с	or es e consequence of):			
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ng physicia s es the bur Medical	Ceuse (Disease or injury that initiated events resulting in deeth) Lest	cDue to (	or es e consequence of): sulting in the underfying ceuse given in	n Pent I. 23b. Did	tobacco uee contr	ibute to the cause of de
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he Funeral Director: After this certificate has been signed by the attending physicia pletely filled in by the funeral director, page 2 should be detached for use es the burdelety filled in by the funeral director, page 2 should be detached for use es the burdelet filled in the filled for the filled filled for the filled for the filled for the filled filled for the filled filled filled filled for the filled fill	Ceuse (Disease or injury that initiated events resulting in deeth) Lest  Part II. Other significant condition  25. Wes case referred to medical exeminer?  1	Due to (  d	sulting in the underlying ceuse given in the underlying ceuse give	24e. West performance of the state of the st	Yes 20 No 3 en eutopsy ormed?  Yes 20 No one) dence 6 Other how injury occurred  Street end Number wn, Stete)  ceuse(s) end menr dete end place, en	completion of ceuse of deeth?  1  Yes 2 No  (Specify)  or Rurel Route Number,  her es steted. d due to the cause(s)  (Month, Dey, Year)
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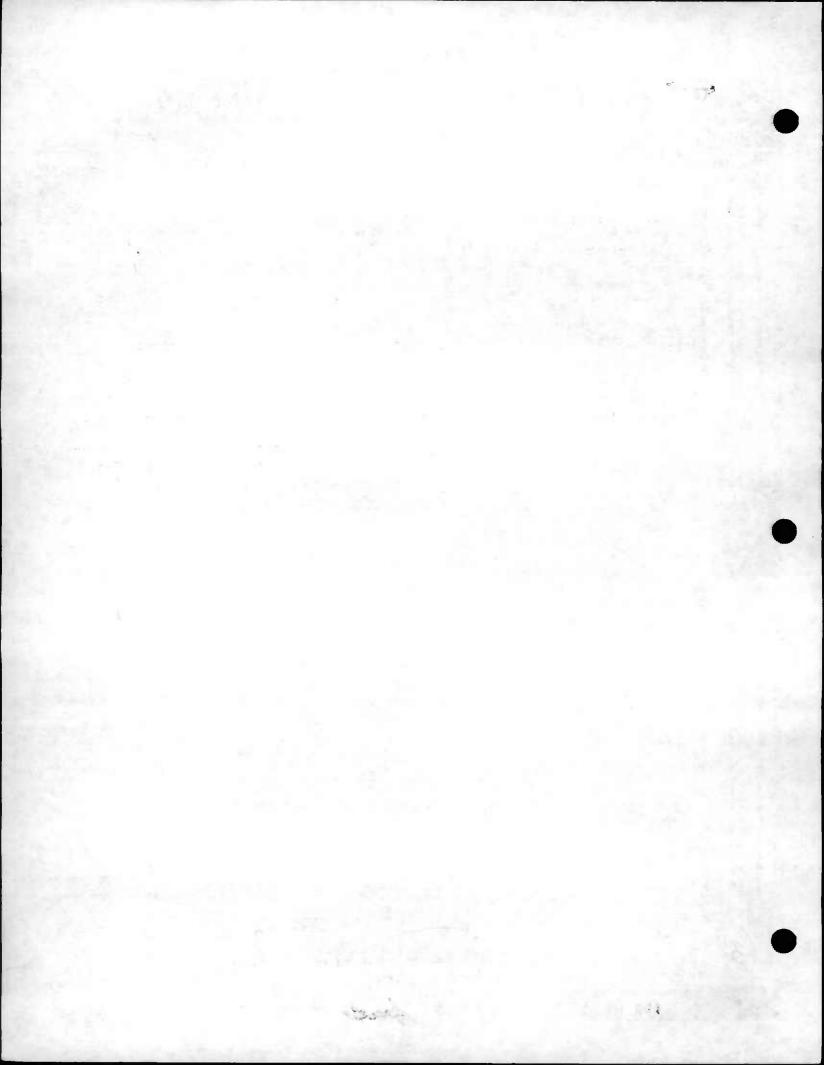
DHMH 16 Rev 6/95

fitte nanna

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 14599

Sual Residence of Decedent  Da. State  10b. County  Md.  Prince Go  De. Street and Number  13809 Brightwood I  1. Marital Status  1 Never Married 2 Married  3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  2 th	REPORT AND	ast birthday) Yrs.  Town or Lo		Year Days	COLUMB	I A Hrs.	2. Date of Dea Month April cation of Death  8. Date of Birth (Month, Day July 1,	Ac. County Howa!	9. Birthp Cour	3. Time of Death 23 2-5  place (Stete or Foreity) eroon, CA
A Facility Name (If not institution, give so HOWARD COUNTY GET Social Security Number 6. Sex 13-31-0073  Sual Residence of Decedent 10b. County Md. Prince Got 13809 Brightwood I 1. Marital Status 1 Never Married 2 Married 3 Widowad 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2th	NERAL HOSPITAI  NERAL HOSPITAI  7. Age (In yrs. I  33  10c. City  Derges La  Drive #1611  12. Was Decedent Evar in U.; Armed Forces? 1   Yas 2x   No If Yes, Give Yaar of Datas:	ast birthday) Yrs.  Town or Lo	Months Cation	Year Days	COLUMB	I A Hrs.	cation of Death  8. Date of Birth (Month, Day	4c. County Howan	of Death  of Death  d  9. Birthp  Cour	place (State or Forei
A Facility Name (If not institution, give so HOWARD COUNTY GET Social Security Number 6. Sex 13-31-0073  Sual Residence of Decedent 10b. County Md. Prince Got 13809 Brightwood I 1. Marital Status 1 Never Married 2 Married 3 Widowad 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2th	NERAL HOSPITAI  NERAL HOSPITAI  7. Age (In yrs. I  33  10c. City  Derges La  Drive #1611  12. Was Decedent Evar in U.; Armed Forces? 1   Yas 2x   No If Yes, Give Yaar of Datas:	ast birthday) Yrs.  Town or Lo	Months Cation	Year Days	COLUMB	IA Hrs.	8. Date of Birth (Month, Day	Howar	9. Birthp Cour	
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Sual Residence of Decedent  Da. State  10b. County  Md.  Prince Go  De. Street and Number  13809 Brightwood I  1. Marital Status  1 Never Married 2 Married  3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)  2 th	Derges La  Drive #1611  12. Was Decedent Evar in U.; Armed Forces? 1   Yas 2\( \delta \) No If Yes, Give Yaar or Datas:	Town or Lo	cation		Hours		July 1,	1966		
sual Residence of Decedent Da. State 10b. County Md. Prince Go De. Street and Number 13809 Brightwood I 1. Marital Status 1 Never Married 2 Married 3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2 th	Derges La Drive #1611  12. Was Decedent Evar in U., Armed Forces? 1   Yes, 2X   No If Yes, Give Yaar or Datas:	urel_	10f. Zip C	code				1700	Cam	Croom, on
Md. Prince Go De. Street and Number  13809 Brightwood I  Marital Status  1 Never Married 2 Married 3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12) 2 th	Derges La Drive #1611  12. Was Decedent Evar in U. Armed Forces? 1 □ Yas 2½ No If Yas, Give Yaar or Datas:	urel_	10f. Zip C	ode						
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De. Street and Number  13809 Brightwood I  1. Marital Status  1 Never Married 2 Married  3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  2 th	Drive #1611  12. Was Decedent Evar in U, Armed Forces? 1 □ Yas 2 No If Yes, Give Yaar or Datas:			ode						1 DXYas 2 □
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3 Widowad 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2 th	If Yes, Give Yaar or Datas:		Yas, specify	y Cuba	n, Mexican, P	uerto I	ecify Yas or No- Rican, etc.)	Bla	ck, White,	
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 2 th		1	□ Yes 2	XNo	Specify:			Specif	y: Bla	ck
(Specify only highest grade Elementary/Secondary (0-12) 2th	estion	16a Deced	lent's Usual (	Occupa	ation			16b. Kind of B		
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		SETT	Empro	yeu	18 Mother's	Name	(First, Middle,			
7. Father's Neme (First, Middle, Last)  Leon Loe							ouise	www.r. gurnar		
9a. Informant's Name/Relationship (Ty)	pe, Print)						I Route Numbe 北ハウ			
Fils Loe/Brother		12300	) Feat	her	wood_D	riv	e, Šilv	er SPr	ing,	Md. 209
The state of the s	01	ace of Dispo	sition (Name	07	a)	į	Date	20c. Location	- City or To	wn, State
4 □ Donation 5 □ Other (Specify)	Dot	iala C	emeter	У	5/	5/0	0	Camero	on, C	entral A
1. Signature of Funeral Servica License	e 1	22	. Name and	Addres	s of Fecility	Jo	hnson 8	Jenki	ns In	с.
1 Believe - A	/ and	_ 7	16 Ken	ned	y St,	N.W	. Wash.	D.C. 2	20011	
The fact the disease or see the		Do not ont	au tha mada	of chim	a such as as	relia a a		rant .	-	Approximate
shock, or heert failure. List only on	e cause on each line.	. DO NOT BIN	el the mode	Or dynn	g, 30011 a3 0a1	Giac o	i respiratory an	1031,	1	Interval Between Onset and Death
- madiate Cause /Final		11165	- ,	0		00	1.00	0	1	16
lisease or condition		-	rick.	le	ce	<u> </u>	Disea	2	1	years
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ert II. Other significant conditions con	tributing to death but not resu	ilting in the u	nderlying cau	se give	en in Pert I.		23b. Did t	obacco uae co	ontributa t	o the causa of de
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1114						_	4_	,	,	
									24b. W	ere autopsy finding
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E Was once referred to medical					00 51			-		- 100 4CT40
examiner?	ospital:			Oth	or:					v 1
TEL YES 22-NO	1 LU Inpatient 2 LJ	10000		1	4 LI NUISI	-				79)
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3 ☐ Suicide 6 ☐ Could not be	On Die (1)				. ee Z [] NO		20f Looption #	Strant and M.	her or D	al Bouto Alumba
4 ☐ Homicide determined	building, etc. (Specify	me, rarm, str	eet, tactory,	οπισο					Uer or mun	zi i loute ivuilioel,
(Check only 2 Medical Examir										
one)	and manner stated.									
9b. Signature and title of certifier	02	-	29c.	License	e number	2.0		29d. Date sign	ed (Month,	Day, Year)
fritan	200			De	284	10		April	15,0	2000
0. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print) PR	17	am	5	SAIN	IMA		
ain chea	RY I DHAT	-							_	
TIPE K	1 LANTIN B	2	UITTE	2	-11	1	AUREI	_ MD	, 20	80/0
	Da. Method of Disposition  1	20b. P. Compared to the death of the death o	Due to (or as a consequentially list conditions, any, leading to immediate ausse. Enter Underlying leuse (Disease or injury latinitiated events southing in death) Last  Due to (or as a consequence of least) Last initiated events southing in death) Last  Due to (or as a consequence of least) Last initiated events southing in death as a consequence of least le	20b. Place of Disposition   12   Cremation   3   Ramoval from State   20b. Place of Disposition   12   Cremation   3   Ramoval from State   20b. Place of Disposition   12   Crematory or other   12   Conditions   12   Crematory or other   13   Crematory or other   14   Crematory or other   14   Crematory or other   15   Cremato	20. Place of Disposition   20. Place of Dispos	28. Method of Disposition   10   28   28   29   29   20   29   29   29   29   29	20. Place of Disposition   10. Place of Disposition (Name of Cambridge), Grematory of other place)   20. Place of Disposition (Name of Cambridge), Grematory of other place)   20. Place of Disposition (Name of Cambridge), Grematory of Other place)   3. Signature of Funeral Servica Licensee   22. Name and Address of Fecility   3. Place of Disposition (Name of Cambridge), Grematory of Other place)   3. Signature of Funeral Servica Licensee   22. Name and Address of Fecility   3. Place of Disposition (Name of Cambridge)   3.	20. Place of Disposition   Date	20b. Piace of Disposition   Date   20c. Location   Date   20c. Location   Cameron   Cameron	20. Palace of Disposition   1/4   Donation   3   Ramoval from State   20. Enace of Disposition   1/4   Donation   5   Other (Specify)   Doual a Cemetery   5/5/00   Cameroon, C



and ettending physician for use as the buna Box 68760, P.O. | Records, Division of Vital

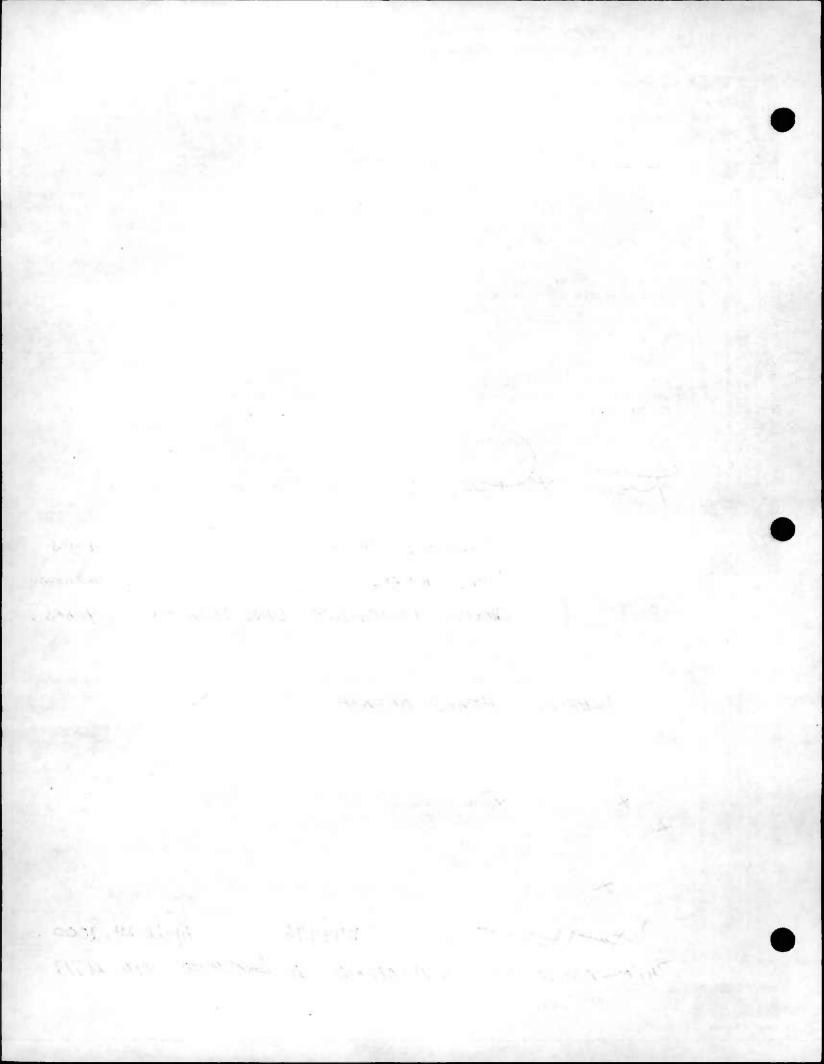
Reg. No. 1. Decedent's Name (First, Middla, Last) 2 Date of Death 3 Time of Death Month Year **Physician** 6:05AM Patricia Ann Munson 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 25, 1936 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (Stete or Foreign Country) **Funeral** Months 1□ M 2□ F 217-32-7384 63 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Washington Smithsburg 1 ☐ Yes 2 ☑ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 2247 Jefferson Blud. P.O. Box 366 21783 U.S.A. 'naturel', or items 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade complated) other then Elementary/Secondary (0-12) Cottege (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if flem 27 is marked othe eny injury or other treumatic event, bace. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Russell Edward Hammersla Helen C. Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Vernon Wayne Munson (Husband) 2247 Jefferson Blvd. P.O. Box 366 Smithsburg, Md. 21783 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Apr. 27 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State Donation 5 Other (Specify) Cedar Lawn Memorial Park 2000 Hagerstown, Md. 22. Name and Address of Fecility 2 Signature of Funeral Service License 12525 Bradbury Ave. Pavis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RESPIRATORY Examiner Dua to (or as a consequence of) Physician/Medical Examiner LYNG CANCER unknown Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): OBSTRUCTIVE CHRONIC LYNG DISTASE. Due to (or as a consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 XYes 2 □ No 3 Probably 4 Unknown p 24b. Wara autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was en autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No lal or Attending Physicien: The state death.

It Director: After this certificate ed in by the funeral director, pe 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Naturat 1 Tyes 2 □ No 2 Accidant 3 Suicide 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, end dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D44996 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

20 31/ CAPPANS BOONSBORD ZAFAR MAZIK 32. Registrer's Signature 31. Date filed (Month, Dey, Year) APR 2 5 2000 State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MARGARET MARIE MURRAY 18 2000 8:05 AM April 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Genesis ElderCare -The Pines Talbot Easton If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) Deys 10 M 2 KF Months Yrs 202-12-1442A 88 March 19, 1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 109 Conner St. U.S.A. 21663 11. Marital Status 12. Was Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No Specify: Specify: 3X Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Restaurant 8 Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Edward Green Mary Della Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Arlene M. Thomas Daughter P.O. Box 161 St. Michaels, Maryland 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State April 22, 1 Nuriel 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Thomas Memorial Cemetery | 2,000 St. Michaels, Maryland 22. Name and Address of Fecility Harrison E, Leonard Funeral Home 21. Signature of Funeral Service Licenses 312 S. Talbot St. St. Michaels, Maryland 21663 23a. Pert1. Enter the disease, or complication; thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events resulting in deeth) Las! uller Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the causa of death? thritis 1 Yes 2 No 3 □ Probably Vunknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 

Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2K No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 ☐ Could not be determined

Physician/Medical Examiner The law requires that the deeth certificata be executed ettending physicien and for usa as the burial-tran P.O. Box 68760, Be Completed by ate has been signe pege 2 should be this certificate director Medicai Certification: To funeral Affer

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

**Funeral** 

Director

288-1

Pages 1 and 2 should be liked within 72 hours after nits of Health Hygiene.
Intel I feet 27 is marked other than "natural", or its any of other thaumals event, the Medical Examinist ary of other thaumals event, the Medical Examinist.

important: If it any injury or o

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

argaret Murray

ð g 238

or Attending Physician:

Records, Division of Vital To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af filled in by completely

> State Registrar

**DHMH 16 Rev 6/95** 

APR 2 0 2000

29b. Signature and litle of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of death (Mem 23a) (Type, Print)

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)

508

MICHAEL 31. Date filed (Month, Day, Year)

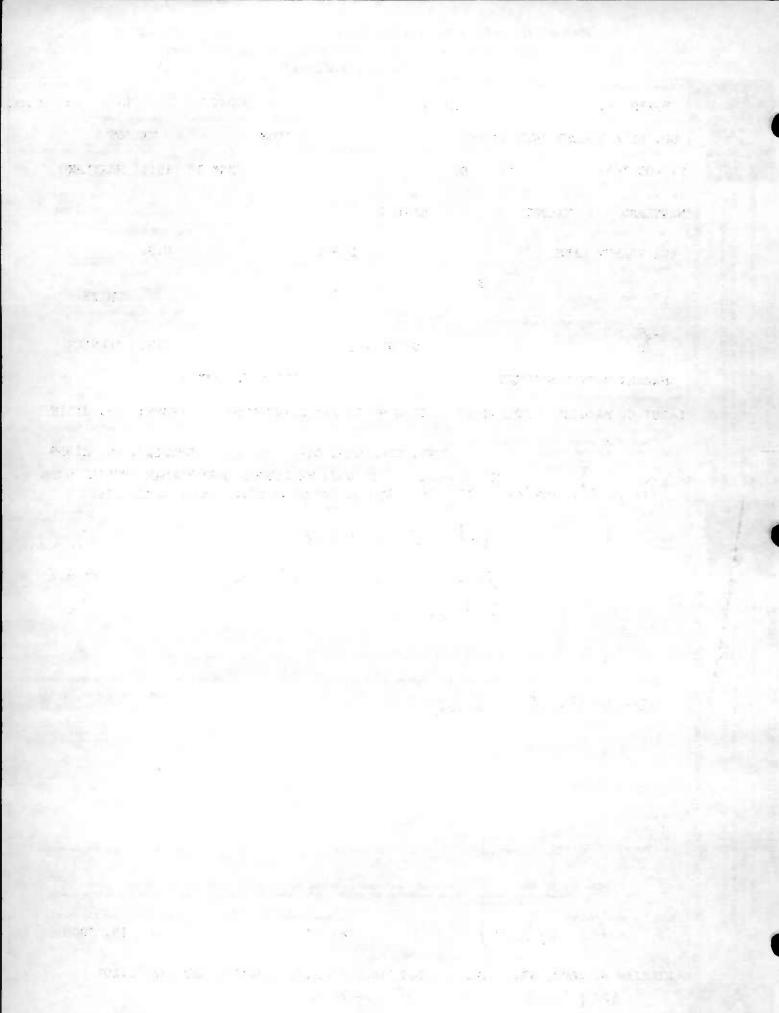
CROWLEY

32. Registrer's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene	-	
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Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth April **Physician** 2000 6:10a.m. DORIS A. Macneal /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** WM. HILL HEALTH CARE CENTER EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 M 20 F Months Hours Yrs. MARYLAND Director JUNE 30, 1911 212-03-7671 88 Usuel Residence of Decedent death with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 23a-1 ahov say injury or other trsumatic event, fine Medical Examiner must be notified at once. Yes 2 No **EASTON** MARYLAND TALBOT Directo 10e. Sfreet end Number 10f. Zip Code 10a. Citizen of Whet Country? 601 WALNUT LANE U.S. 21601 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: ð 3€ Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SECRETARY CIVIL SERVICE 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ADELE V. LETCHER CHARLES MARTIN STRUVEN 2 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 42 G QUEEN CATHERINE COURT CHESTER, MD. 21619 Leroy C. Macneal / STEP-SON 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHES. CREMATION CTR 4-18-00 CHESTER, MD. 21619 21. Signature of Funeral Service Licensee 2. Name and Address of Fecility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD. 21601 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner 1 card The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last pue burial-tran P.O. Box 68760, ettanding physicien Physician/Medicai the Due to (or as e consequenca of) use as t lor Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by t 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy peeu has pege 2 certificata 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: funeral diractor Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Mapner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Waturel 5 Pending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined a 24 hours after dea to Funeral Director plataly filled in by th 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 29a. Certifier 🗹 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated Medical complataly 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end manner stated. (Check only one) within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) William Horoso D08715 APRIL 15, 2000 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) WILLIAM H. 508 IDLEWILD AVE. EASTON, MARYLAND 21601 WOOD, JR., M.D. 32. Registrar's Signature State Registrar



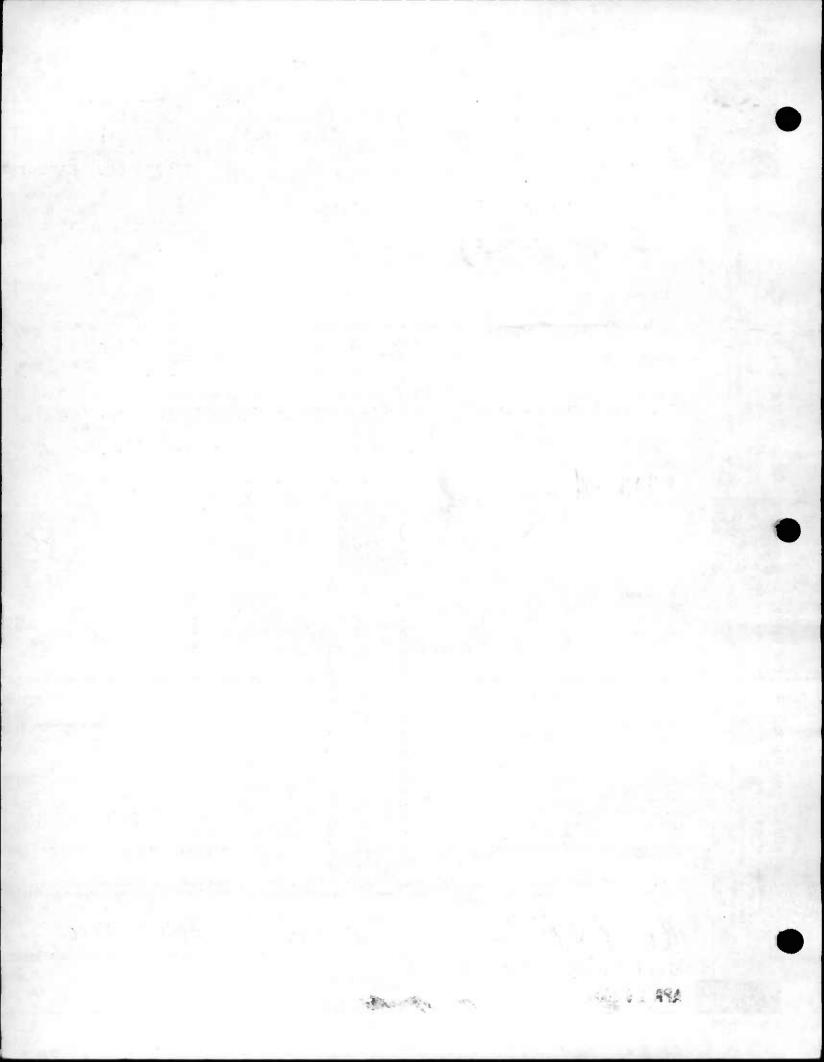
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No 1. Dacedant's Nama (First, Middle, Last) 2. Date of Daath 3. Tima of Deeth **Physician** FANNIE B. MATTHEWS Month 17, APR. 2000 1:30 PM /Medical 4a. Facility Nama (If not institution, giva straat and number, 4b. City, Town, or Location of Daath 4c. County of Death Examiner NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY 5. Social Sacurity Number If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1 □ M 2 X F 579-84-9421 Yrs. 97 Director JULY 4,1902 NORTH CAROLINA Usual Rasidance of Decedant death with the Maryland 10b. County 10a. Stata 10c. City, Town or Location la or 28a-f show 10d. Insida City Limits MD. MONTGOMERY ROCKVILLE Director 1X Yas 2 □ No 10a. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 r than "natural", or Items 23s USA Funeral 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. filed within 72 hours efter 1 Naver Married 2 Marriad 1 ☐ Yas 2 XNo If Yes, Giva Yaar or Datas: 21215-0020 1 ☐ Yas 2 🛣 No Specify: Specify: BLACK Completed by 3 X Widowed 4 ☐ Divorced 16a. Dacedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) al Hygiene. Elamantary/Sacondary (0-12) Collage (1-4or 5+) UNKNOWN permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygiel Important: If Item 27 Is marked other th any Injury or other traumatic event, Ing 2010: 12 NOT AVAILABLE Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be LOT MURRAY ROSA ANNIE MURRAY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) REV.DR. REICHARD-EXECUTOR 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850 20b. Place of Disposition (Name of camatery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 █ Burial 2 ☐ Cramation 3 ☐ Removal from State GLENWOOD CEMETERY APR.19-WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signatura of Funaral 🎮 22. Nama and Addrass of Facility HYSONG CO., INC. et caused tha deeth. Do not anter tha moda of dying, such as cardiac or respiretory errest, 23a. Pert1. Entar the disaase, a shock, or haart failura. Li Approximate Interval Batwaan Onsat and Daath **Physician** Immediete Causa (Finel disaasa or condition rasulting in daath) /Medical Examiner Dua to (or as e consequence of Physician/Medical Examiner 10109 Sequentielly list conditions, if any, laading to Immadiate ceusa. Entar Undarlying Cause (Diseasa or Injury that initiated events the burist-tra P.O. Box 68760. certificate be Due to for es consequance of) rasulting in daath) Last **USB 85** Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the cause of death? yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, À Completed 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed? The law page 2 has 918 2 🗹 No 1 Tas 1 ☐ Yas 2 ☐ No this certific Be 25. Was cesa rafarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After Natural 5 Panding invastigation death 1 □ Yas 2 □ No after death Director: A 2 Accident 3 Suicida 6 Could not be determined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 4 I Homicide To the Hospital within 24 hours a To the Funeral D edical 29a. Certifian Certifying Physician: To tha bast of my knowladge, daath occurred at the tima, data and place, and dua to tha causa(s) and mannar as statad. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mennar stated. 29b. Signature and title of 29c. Licansa numbar 29d. Data signed (Month, Day, Year) pril 18 2000 ated ceusa of death (Itam 23a) (Type, Print) 500 Ameranth

State Registrar

32. Registrar's Signatura

Dr



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 15,2000 Month **Physician** 18:01p.m. Ronald Albert Moten April /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Prince Georges Hospital Cheverly Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Mar, 15 9. Birthplece (State or Foreign Country)
Wash., D.C. 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Deys , 1932 15 M 2□ F 68 577-48-0619 Yrs Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturer", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Director Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e, Street end Number 10f. Zip Code 10900 Mt.Lubentia Way 20774 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 ☐ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. peopli. Pages 1 and 2 should be filled within 72 hours after a Repartment of Health and Mental Hygiens him process; or other traumatic event, the Medical Francisco. Black, White, etc. 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: Korean Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Postal Worker 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 Elmer Moten Mae G.Dawes 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Audrey Moten (Wife) 10900 Mt.Lubentia Way, Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft.Lincoln Cemetery 4-20 Bladensburg, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Lewis Funeral Home 21. Signeture of Funeral Service Licenses 311 N.Patrick St., Alexandria, Va, 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) Aviedical Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) P.O. Box 68760, that initiated events resulting in death) Lest Due to (or es e consequence of) 23b. Did tobecco use contribute to the carea of deeth? Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert i. is carificate has been signed by the director, page 2 should be datached Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records. ģ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No 2 1 No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this cartification plately filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpetient DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending Investigation Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifie 29c. License number 500 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Hospital Dr. Chevery, Mce, 3001 Dr. Meera Kanhouwa 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

DHMH 16 Ray 6/95

State Registrar may first, life Life 

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

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by Funeral Director	3		ried 2□ Man	ried	12. Was De Armed F 1   Yes If Yas, C Year or	Forces? 2 🔯 N Sive			Was Decedent If Yes, specify 0		(Specify Yes or No uerto Rican, etc.)	14. Rad Bla Specil	ce - America ick, White, a ly: W	
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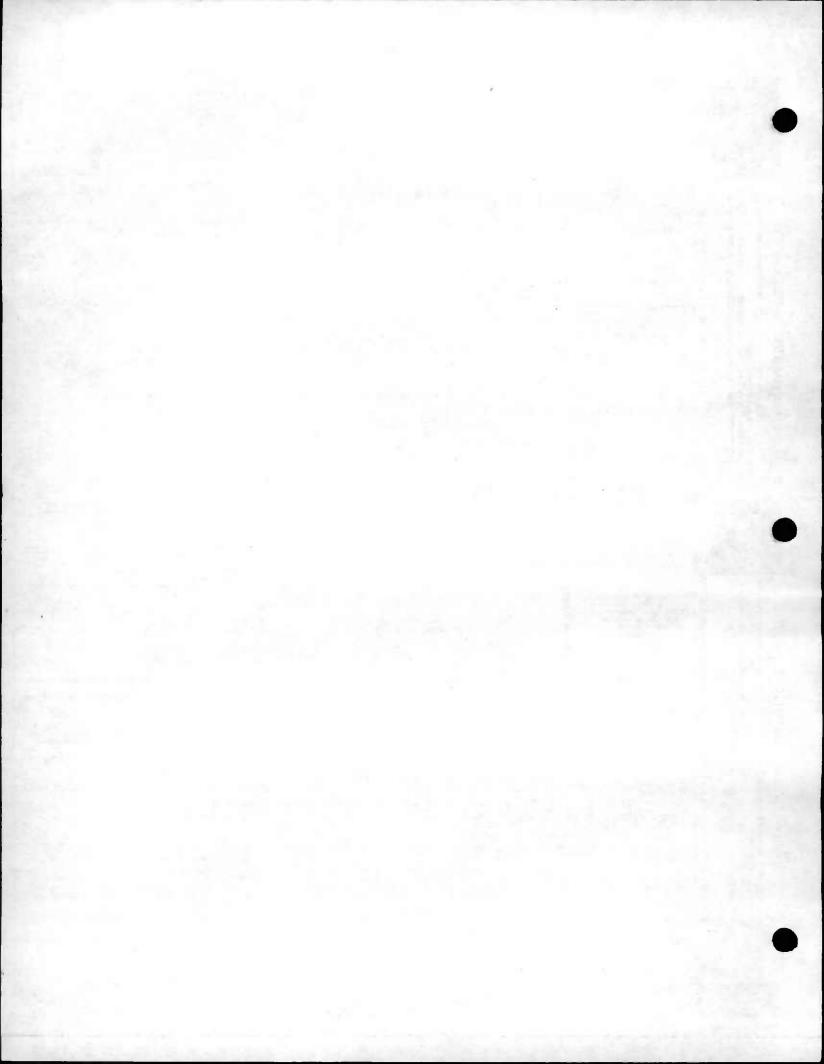
Registrar

31. Date liled (Month, Day, Year)

APR 2 1 2000

Sparks

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 4 P.M. Merson APri, 16, 2000 4c. County of Death 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Maple Da ber 6. Sey USI M 20 F Road If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, orchester 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Deys 215-26-4486 1912 Maryland Director lug, 27, Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location Items 23a or 28a-f show 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryle Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinating the profited at Director 1 Yes 2 No ambridg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12. Wes Decedent Ever in U,S.
Armed Forces?
1 | Yes 2 DMo
If Yes, Give
Year or Detes: 4410 2/6/3

13. Was Decedent of Hispenic Origin? (Specify Yes or Noif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Funerai 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0026 1□ Yes 2 No Specify: ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Private 6 -armer 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be Stanler P Nathaniel erry 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Cambridge, M.D. 21613 Sandra Dorsey Road e Dam 20a. Methed of Disposition 20c. Location - City of Town, Stete Date 1 Burial 2 □ Cremetion 3 □ Removal from State ucktown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1222000 Cambridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Henry Funera 23a. Perfi / Enter the disease, or complications that caused the denshook, or heart failure. List only one cause on each line. 510WaSh water St Cam
Do not enter the mode of dying, such as cerdiac or respiretory errest MD, 21613 ambridge Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Ceuse (Final disease or condition resulting in death) years Examiner Due to (or es e consequence of): Physician/Medical Examiner Mellitus ettending physician end for use es the bunal-transit The law requires thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Records, P.O. Box 68760, TYPERTENSION that initieted events resulting in deeth) Last Due to (or es e consequence of): 0000000 BC Lean Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown ò director, pege 2 should Completed 24a. Wes en eutopsy 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? After this certificete hes 1□ Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funerel Director: After this certifica completely filled in by the funeral director, to Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer)

State Registrar 31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)

503 BYEN ST

32. Registrar's Signature

SUITE

Cambridge MD 21613

AFR 1.9 2000 January & January

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of

f	Maryland /	Depa	artme	nt of	Health	and	Mental	Hygiene	
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Examine	An English Mann III and Inglish					4			cation of Death		y of Deeth	TON
Funeral Director	5. Social Security Number 218–50–2573		7. Age (In yrs. 60	last birthdey) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Bir (Month, De MAY 9,		9. Birthp	place (State or Fo
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or 2	10e. Street and Number				10f. Zip					10g. Citizen of		ntry?
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al', or itema 23. Exerciper must by Funeral	11. Marital Status 1 □ Never Married 2 ☑ N 3 □ Widowed 4 □ Divord	Armed For	2 <b>⊠</b> No 9		Was Decedo If Yes, speci 1☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto f	cify Yes or No Rican, etc.)	Speci	ce - Americ ick, White, fy: Wh	
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7 is marked other traumatic event, To Be Co	BENJAMIN FRAN	KLIN STILL					CLYDE	т, мат	DALETNE	E LEWIS		
To To	19a. Informant's Name/Relation			10h Maiiir	na Address	(Street s				er, City or Town	State Zir	Code)
To B												
Hem 27 I	WILLIAM S. RO  20a. Method of Disposition	W/SPOUSE	20h D	Page of Dispo			SHAKE	SBUI	RG, MAF	20c. Location	21782	
	1 ⊠ Burial 2 ☐ Crematic			emetery, crei	metory or of	her plac	e)					
Juny	4 Donation 5 Other		FA	IRVIEW					22/00	KEEDYS	VILLE	, MARYL
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NAME: ROW, SHIRLEY LORRAINE 05/09/1939 60 / F

DOS: 04/15/2000 GUEDENET,ROBERT J.S.





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** John Reinoehl, Sr. 19, 2000 Apr 9:11 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (II not institution, give street end number) Examiner Anne Arundel Medical, Center Annapoli If Under 24 Hrs. Anne Arundel If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys M 2□ F Months Hours Director 579-10-6445 1924 Wash. Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or flerra 23a or 28a-f show Examiner must be notified at 15 Yes 2□No Director MD Anne Arundel Tracys Landing 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Ark Haven Funeral 524 20779 USA Road 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - Americen Indian, 11. Marital Status Bleck, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 3 Merried 1 ☐ Yes 2 No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced WWII white Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed with el Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Banking Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) . Pages 1 end 2 should be fit traint of Health end Mentel Hant: If them 27 is marked oth jury or other traumatic even Be 2 Raymond C. Reinoehl Mable Urich 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health e Important: If Nem 27 Is eny Injury or other tra Tracys Landing, MD 20779
Dete 20c. Location - City or Town, Stete 524 Dorothy Reinoehl/spouse Ark Haven Road, 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Memorial Gardens 4/22/00 Dunkirk, MD 22. Neme end Address of Fecility 21. Signature of Funeral Service Lid Raymond-Wood Funeral Home P.O. Box 430, Dunkirk,

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Dunkirk, MD 20754 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner physicien end s the buriel-trensit umonla Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): esn Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 XNO 3 Probably 4 Unknown 1 ☐ Yee signed t semo by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed hes 1 ☐ Yes 25. Wes cese referred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Nopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2 ☐ ER/Outpetient 3 ☐ DOA this Dete of Injury (Month, Dey Year) 27. Manner of Death 28a 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Naturel 5 Pending investigation efter death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 \ Homicide

the death certificete be executed Box 68760. P.0. Records, requires The lew of Vital Division Attending ò Hospital

with the Marylend

hours efter

altimore, Maryland 21215-0020

To the Hospital within 24 hours or To the Funeral Completely filled 29b. Signature and Ittle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 304Name and address of gerso who completed ceuse of deeth (Item 23e) (Type, Print) 25 6 32. Registrar's Signeture 31, Dete filed (Month, Dev. Year) State 2000 Registrar

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end manner stated.

2000

2140

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** St. Clair April 19 2000 1721 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton 5. Sociat Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 74 Yrs. July 26, 1925 248-30-5183 Director South Carolina Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo 28a-f Maryland Talbot St. Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? W 23a or 105 Thompson Street Funeral 21663 U.S.A. 12. Was Decedent Evar in U,S. Amed Forces? 1 Å Yas 2 ☐ No If Yas, Giva Year or Datas: WWII or Items 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Maritat Status 14. Race - Amarican Indian. Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elementary/Secondary (0-12) Attorney U.S. Federal Government peamit. Pages 1 and 2 should be the important: If hear 27 is marked other any injury or other traument. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Ernest Ruben Reeves Effie Catherine Reeves 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith S. Reeves - Wife 105 Thompson Street, St. Michaels, MD 21663 Baltimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2000 Arlington, Virginia Arlington National Cemetery 21 Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Dasc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician tmmediata Cause (Final disease or condition resulting in death) /Medical 5 days Examiner Dua to (or as a consequence of): Physician/Medical Examiner Diabetes Nephrosclerosis attending physician and for use as the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): P.O. Box 68760, that initiated events resulting in death) Last Dua to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, 29 24b. Wara autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy performed? Deed has 1 Yas 2 No certificata 1 ☐ Yas 2 ☐ No Division of Vital : After this certifica a funaral diractor, p or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yes \$€No 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. tnjury at Work? 28b. Tima of 1 DNatural 5 Pending 1 24 hours aftar death.

• Funeral Diractor; After the function of the functin 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation in my opinion death occurred. Medical 29a. Certifier within 24 hou to the Fune gompletaly fi iner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and manner stated. (Check only one) ŝ 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 2000 00053110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Dennis DeShields, M.D., The Memorial Hospital, Easton, Maryland 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Rev 6/95

CLAIR REEVES



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day ANN RITA ROSCOE April 16,2000 8:20 PM 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Villa Rosa Home Mitchellville Prince Georges 5. Social Security Number If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days Months 1 □ M 2 🖫 F 83 027-03-4865 Yrs May 12, 1916 Mass. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Prince Georges Seabrook 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 6502 97th, Ave 20706 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married ♣ Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Thomas F. Mosson Ann McCrandel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Roscoe (Husband) 6502 97th. Ave. Seabrook, Maryland 20706 of Disposition (Name of Disposi 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arlington Nat'l Cemetery 5/1/00 Arlington, VA 21. Signature of heral Service License 22. Name and Address of Fecility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 M. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such es cerdiac or respiratory errestick, or heart failure. List only one-cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of) thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street end Number or Rural Route Number, City or Town, State)

Examiner certificate be executed ettending physician and for use es the buriel-trar Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the e should l Completed certificate hes i or Attanding Physician: effer death. Director: Atter this certifica Be Certification: To funeral completely filled in by Hospital 24 hours e Medicai

**Physician** 

/Medical

**Examiner** 

Director

Funerai

Completed

Be ၀

**Funeral** 

Director

death with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Cogarine at the Hallh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show with injury or other traumatic event, the Medical Examinat must be notified at once.

**Physician** 

/Medical

Examiner

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Baltimore, Maryland 21215-0020

25. Was cese referred to medical examiner? 1 ☐ Yes 2 300 27. Manner of Deeth Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

21 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29b, Signature as 29c. License number 29d. Date signed (Month, Dey, Yeer)

Name and eddress of person w completed ceuse of death (Item 23a) (Type, Print)

CAL - m 20716 ANLAN-ILIS NO me

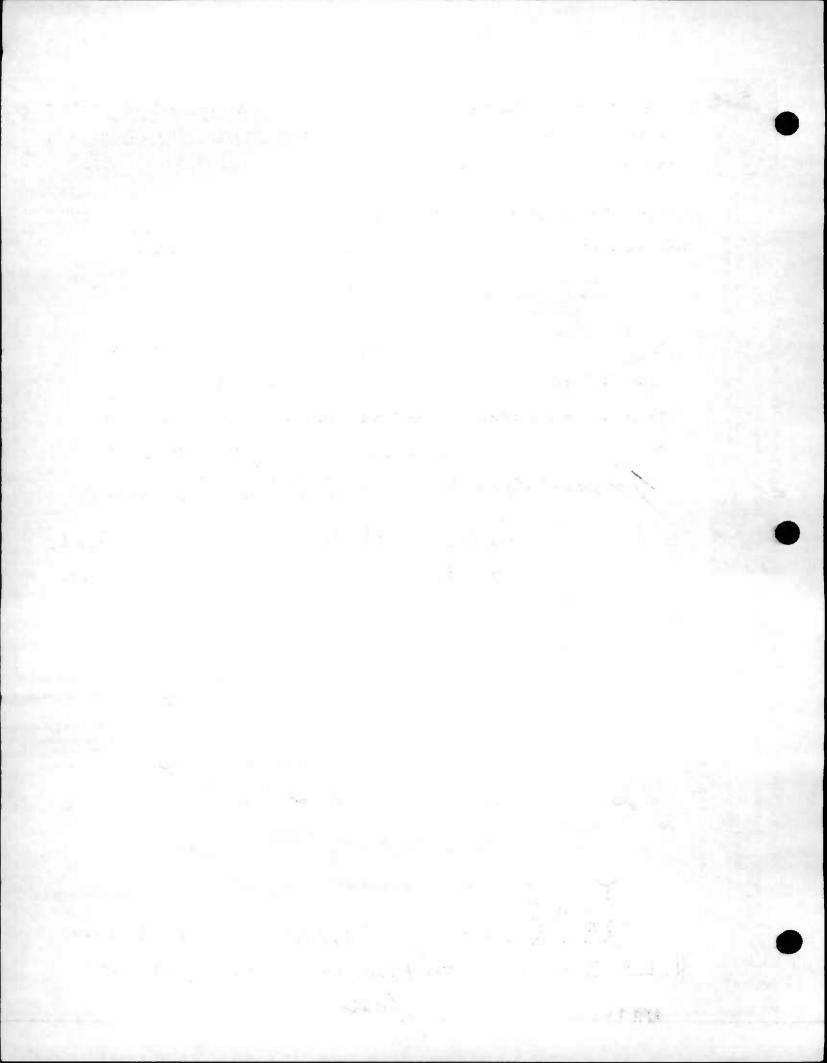
State Registrar

To the Tro the Tro the I

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture



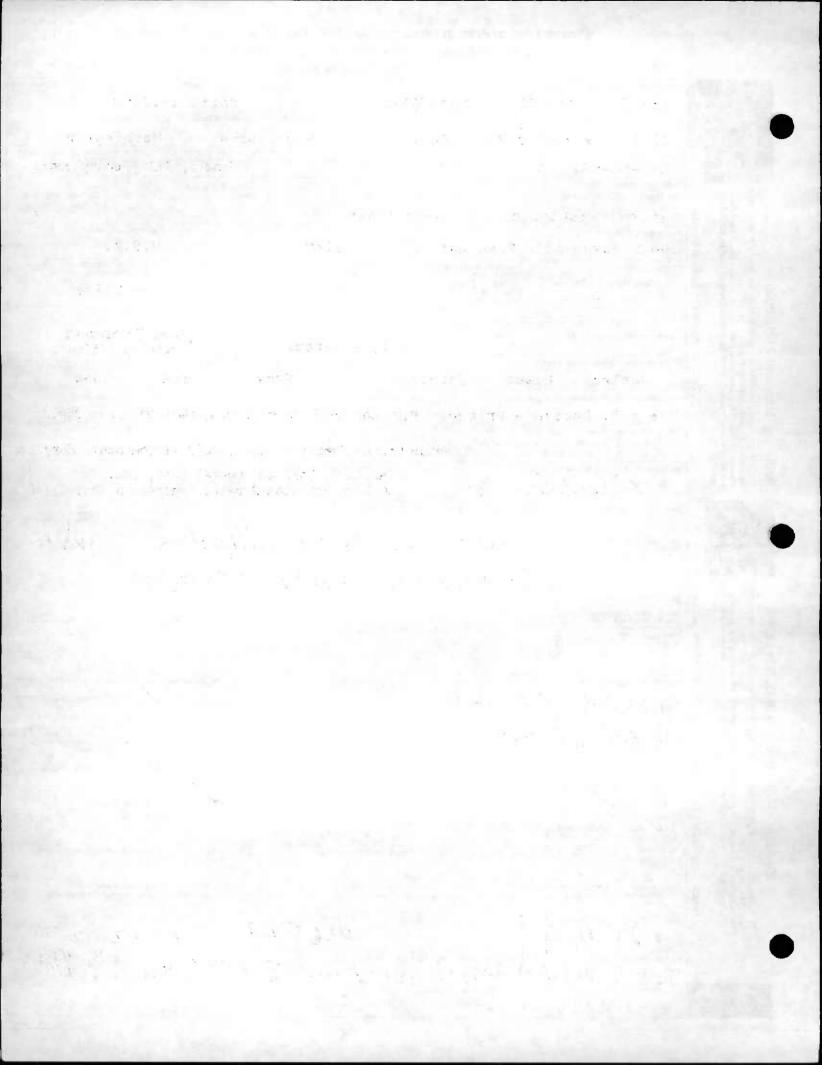
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 46

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) April 19, 2000 **Physician** SAUNDERS LEROY FRANCIS /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 10812 Downsville Pike Apt. 24 Hagerstown Washington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) June 5, 1942 9. Birthplece (State or Foreign Country) Pennsylvania 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 1 M 2□ F 213-40-4839 Director Usual Residence of Decedent death with the Marylend 10h County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Madical Examplest must be notified at 1 ☐ Yes 2 ☑ No Directo Washington Hagerstown Maryland 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21740 U.S.A. 10812 Downsville Pike Apt. 24 Funeral 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after of Department of Haalth end Mantal Hygiene. Important: If flem 27 is marked other than "natural", or iten any injury or other treumetic event, the Medical Franch 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Type Setter Printing Office 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Charles Elmer Saunders Ruby Irene Mose 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene G. Rhodes - Friend P.O. Box 1576, Martinsburg, West Virginia 25402 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 04-21-2000 Tilghmanton, Maryland Manor Church Cemetery 21. Signeture of Funerel Service Licens Andrew K. Coffman Funeral Home, Inc. K. hae 40 East Antietam Street, Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final 140lavalla En disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed sician end buriel-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last physician s the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) 88 USa 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Was en eutopsy 2 12 No 1 ☐ Yes 1 □ Yes 2 □ No cartificate Hospital or Attending Physician: funaral diractor, 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2010 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending death. 1 ☐ Yes investigation 2 Accident after death Director: 6 ☐ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. Medical within 24 ho To the Fune completaly fi 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. (Check only one) To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who cause of deeth (Item 23e) (Type, Print) 1110 Date filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar

ARR 2 0 2000



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth April 20, 2000 **Physician** 5:00 AM Hilda Buck /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6313 Mallard Lane Lothian Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) March 22, 1909 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F Yrs. Maryland 578-46-3972 91 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Director MD Anne Arundel Lothian 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 6313 Mallard Lane 20711 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. 1 ☐ Yes 2001No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify. 3€Widowed 4 Divorced White Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 P.G. County Govt. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other treumatic event RDGs. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Bruce Buck Emma Chaney 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joan Ripple (daughter) 6313 Mallard Lane Lothian, MD 20711 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) Epiphany Epis. Ch. Cem. Apr 25, 2000 Forestville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 So. Maryland Blvd. Owings, MD 20736 Part L Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one rause on each line. Approximete Interval Between Onset end Death **Physician** /Medical nmediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Box 68760. as the Due to (or es e consequence of) P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 4/2 Leiners bengis be dat Records, PV 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital or Attending Physicien: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menger of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending Investigation 1 ENaturel Hospital or Attending n 24 hours after death. He Funeral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one)

Registrar

State

29b. Signature and title

31. Dete filed (Month, Dey, Year)

0

APR 2 1 2000

of death (Item 23a) (Type, Print)

VIIO 32. Registrar's Signature

Hospital

29c. License number

29d. Date signed (Month, Day, Year)

Ste. 111, TRINCE FREDERICK, MS 20628

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** SCHWENK NORMAN FDWARD April 20 2000 11:30 am /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick 114 Westlake Blvd. If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Aug 10, 1938 Wash., 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Funeral Deys 1 M 2 □ F 578 50 2265 Yrs. 61 D.C. Director Usuel Residence of Decedent Show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hypiena. Important: If item 27 is marked other than "natural", or flerm 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at Prince Frederick Calvert Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 114 Westlake Blvd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1961–62 1 Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify ğ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) section head Library of Congress 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Louise Camilla Earl Leroy Schwenk, Sr. Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6355 Meadowland Dr., Dunkirk, MD 20754 Robert Schwenk / brother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 4-21-00 Alexandria, VA Metropolitan Crematory 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee elliam Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** anscess /Medical tmmediete Cause (Final disease or condition resulting in deeth) Examiner Cau UU9 nding physician and use as the burial-trensit that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760 Physician/Medical that initiated events resulting in death) Last use as the Due to (or as e consequença of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by I 12 Yss 2 No 3 Probably 4 Unknown b page 2 should 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy peeu completion of cause of deeth? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D2/463 29d. Date signed (Month, Dey, Year) 80 wer an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sita (Rd. Prina Fredrick, MD 20678)

**DHMH 16 Rev 6/95** 

State

Registrar

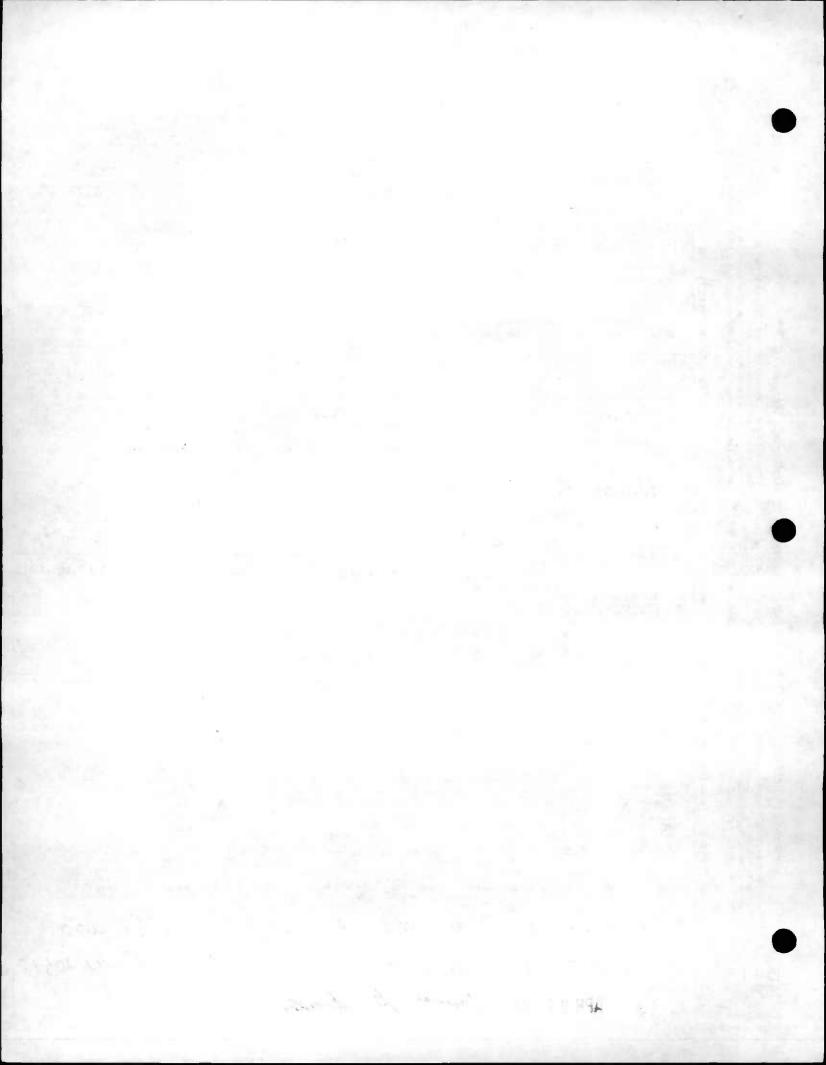
31. Dete filed (Month, Day, Year)

15+1

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APR 2 1 2000 >

32. Registres Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth ARRIE 30 Month Vear 4b. City, Town, or Location of Death 2000 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth CRESENT CITY NURSING HOME RIVERDALE PRINCE GEORGES | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. feb 9, 1914 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign Country)
DOVER, NC 5. Social Security Number 1□M 2\ F 85 Vrs 081-14-3255 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No WASHINGTON DC 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4010 9th ST S.E. #203 20032 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Nevar Merried 2 ☐ Married 1 Yes 2 No Specify: BLACK Specify: 3 DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRIVATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surnama) JOE ROUSE NAOMI WILLIS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) GRAND DEBORAH A. JOHNSON / DAUGHTER 1804 BRANCH AVE S.E. WASHINGTON DC 20020 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State PINELAWN MEMORIAL PARK 4-22-00 4 ☐ Donation 5 ☐ Other (Specify) KINSTON, NC 22. Name and Address of Fecility
ALEXANDER S. POPE FUNERAL HOME 21. Signature of Funeral Service Licenses che 2617 PENN. AVE S.E. WASHINGTON DC 20020 e, or complications that caused the death. Do not entar tha mode of dying, such es cardiec or respiretory errest, List only one cause on each line. Approximete Intervel Batwean Onset end Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? ancience 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa referred to medical examiner? 26. Placa of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28h Time of 28c. tnjury et Work? 28d. Describe how injury occurred Neturel Accident 5 Pending investigation 1 Yes 2 No

Examiner P.O. Box 68760. Records. Division of Vital

Baltimore, Maryland 21215-0020

Physician/Medical Examiner or Attending Physician: this 24 hours efter deeth. filled in by

**Physician** 

/Medical

Examiner

Director

**Funeral** 

Director

natural, or

Hygiene.

permit. Pages 1 and 2 should be the Department of Health and Meetal Hy Important: If Item 27 is marked othe any Injury or other traumatic event pages.

**Physician** /Medical

> Completed by Be Certification: To

Hospital completely within 2 ş State

29a. Certifier (Check only one) 29b. Signeture end fitte of ceptified

3 Suícide

4 Homicide

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D24720 RAVINDER

Cheverly

29d. Date signed (Month, Dey, Year) 4-18-00

K. RUSTAGI MD

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

30. Neme end eddrass of person who completed cause of death (ttem 23a) (Type, Print) andover

31. Dete filed (Month, Day, Year) 32. Registrar's Signature APR 19 2000

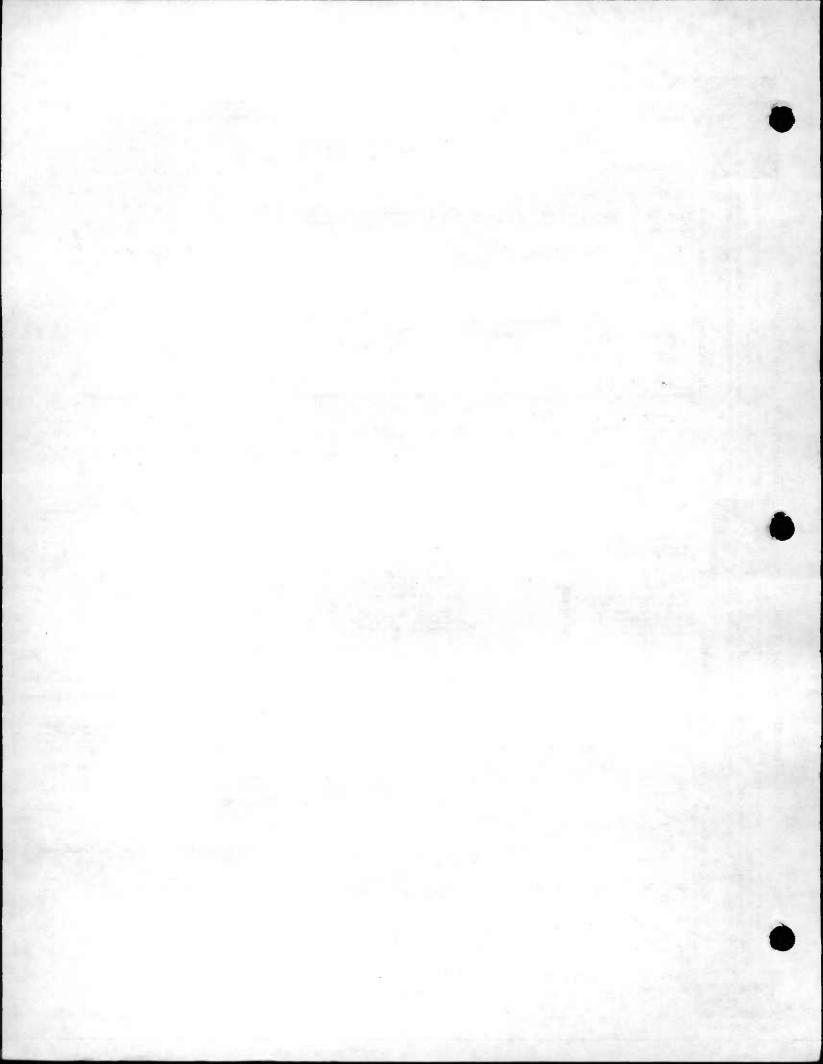
**DHMH 16 Rev 6/95** 

ad

· Jack Comment

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					Cert	ificate c	of Dea	th	F	leg. No.		4615
	1	1. Decedent's Name (First, Middle, La	ist)						2. Date of Dea	th		3. Time of Death
ALL STATES	Physician /Medical	Isabella Steele							Month April	Day 2000	Year O	10:14pm
	Examiner	4a Facility Neme (If not institution, give	e street and number)				4b. City,	Town, or L	ocation of Death			
		SHADY GROVE	ADVENTIST	HOSP	ITA	L		CKVI	LLE	MO	NTG	OMERY
	Funeral	5. Social Security Number 6. 5		(In yrs. last bi	rthday)	If Under 1 Ye Months Da		der 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry)
	Director	061-40-7228	IL M 261 P	86	Yrs.				Dec. 19	, 1913		
	pue *	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Loca	ation					T	10d. Inside City Limits
1	faho faho or	Marriland Mantage										1⊠Yes 2□No
	or 28s-fs to 28s-fs be notified	Maryland Montgome  10e. Street and Number	ery	Gaith	erso	10f. Zip Cod	le			l 0g. Citizen of	What Col	intry?
	after deeth with the Manylen or items 23s or 28s-f show miner must be notified at / Funeral Director		#E11			2087			1			,
	r tema 234 nner muni Funeral	101 Odend Hal Ave	12. Wes Decedent E	ver in U.S.	13. W			Origin? (Sp		Scotlan		ican Indian,
0	Fun Fun	1 Never Married 2 Married	Armed Forces?  1 Yes 2 X N						ecify Yes or No- Rican, etc.)	Bla	ck, White	, etc.
050	elf, o	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:					Specif		ite
Baltimore, Maryland 21215-0020	ied within 72 hours after deeth with the Maryland tygiene. The "natural", or itema 23a or 28a-f show it, the Madical Exercitive must be notified at Completed by Funeral Director	15. Decedent's E (Specify only highest gra	ducation	16a	. Decede	nt's Usual Oc	cupation	nost of work	ina	16b. Kind of B		
2	ithin nple	Elementary/Secondary (0-12)	College (1-4or 5-			ind of work do O NOT use re	tired)	TOST OF WORK	"'9			
2	Yglen Con	12		A	sst.	Nurse				Nursin		
2	d outh	17. Father's Name (First, Middle, Last	)				18. Mo	other's Nam	e (First, Middle,	Maiden Suman	ne)	
3	Men Men To	John Malcolm						ne Dur				
Z a	2 sh end is m rsum	19e. Informant's Neme/Reletionship (							al Route Numbe		, State, Zi	ip Code)
9	l end leelth m 27 her t	Wendy L. Day  20e. Method of Disposition	(Grandchild			Redlion		Pasa	dena, MI		017	- C
Ö	No The	1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemete	ry, crema	atory or other	place)	1	Date	20c. Location	- City or I	own, State
Ë	timen	4 ☐ Donation 5 ☐ Other (Specif		Metro								Virginia
a	permit. Peges 1 and 2 should be filed within 7 Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than 1 important: if item 27 is marked other than 1 in Med bites.   To Be Comple	21. Signature of Funeral Service Licer	nsee			Name and Ad East			Vol Fund	eral Ho	me	
		Wobert .	De Vol		Ga	ithers	burg,	MD 2	0877			
		23a. Part1. Effer the disease, or com shock, or heart feilure. List only	plications that aused one cause on each lin	the deeth. Do e.	not enter	the mode of	dying, such	es cardiac	or respiretory en	est,		Approximete Interval Between
	Physician										1	Onset and Death
	/Medical Examiner	Immediate Ceuse (Finel disease or condition	a Septic S	Shock							i 1	12 Hours
		resulting in death)		Due to (or es a	consequ	ence of):					1	
	sit ed	1600	b. Gram Neg	gative	Bact	eremia					i	12 Hours
	death certificate be executed attending physicien end set for use es the bunal-transit sician/Medical Examiner	Sequentially list conditions,	ı	Due to (or as a	consequ	ence of):						
68760,	icien buria	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury	C								i	
387	phys s the	that initiated events resulting in death) Last		Due to (or es a	conseque	ence of):					İ	
-	7 00		d									
Вох	atter   for u								Transaction			
P.O.	et the death cer d by the attendir atached for use Physiclan/A	Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the und	lerlying cause	given in Pa	art I.				to the cause of death?
	v requires thet the death cer been signed by the attendir should be detached for use leted by Physician/N								ישי	es 2⊠ No	3   Pro	obably 4 Unknown
rds	n sign								24a. Was a		24b. V	Vere eutopsy findings
00									perfor	med?	( c	vailable prior to ompletion of cause f death?
Re	The lew state has to pege 2 s								10 Y	es 2181 No		☐Yes 2☐No
ā	certificata rector, peg	25. Was case referred to medical					06.0	leas of Deat	h (Check only o	277.00		165 20140
5	Physician: this certific ral director, TO Be	examiner?	Hospital: 1 1 Inpatier	ot 2□EB/O	utnations	3□ DOA	Other				har /Snac	<i>i6.</i> )
ō	or this eral di	27. Menner of Death	28e. Dete of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								ny)	
o	ith. : After e funer	1 XXNatural 5 ☐ Pending investigation						rk?  Yes 2 □ No				
Division of Vital Records,	Attending in death.  octor: After by the fune lification	3 ☐ Suicide 6 ☐ Could not b	286. Piece of Inju	ry - At home, fa	arm, stree	et, factory, offi	ice	-			ber or Ru	ral Route Number,
ă	tal or Attending P rs aftar death. al Director: After t led in by the funer Certification:	4 ☐ Homicide	building, etc.	. (Specify)					City or Tow	n, State)		
			ysician: To the best of									
	he Hosp in 24 hou he Fune plately fil edical	(Check only one)  2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, a and manner stated.										to the cause(s)
1	Your Your Your Your Your Your Your Your	29b. Signature and title of openities				29c. Lic	ense numb	er		29d. Date signe	d (Month	, Day, Year)
6	10	ento fr	Lender	s N	10		D 265	40		April 1	5, 2	000
		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type, P							
		Carl Schoenberg, 1	MD 16220 I	Frederi	ck R	oad, G	aithe	rsburg	g, MD			
	State	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	6	1						
Control of	Registrar	APR 182	000 Sene	~	D.	Soon	Kal					



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Amend #19b, 4/19/2000, JW, Mont. Co. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 10,2000 **Physician** AULINE 3:05AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Dey, Year) 10/7/1909 If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Davs 1□ M 2₽F 217-32-2901 90 Director WEST VA. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at MD. MONTGOMERY SANDY SPRING 1 X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17401 NORWOOD ROAD 20860 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 Yes 2 No 1 Never Married 2 Married 1□ Yes 2□No Specify: WHITE Specify p 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LIBRARIAN U. OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WALTER FREDERICK EUGENIA WELLS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20860 19a. Informent's Name/Reletionship (Type, Print) C. FREDERICK STABLER(SON) ILNEY SANDY SPRING RD, SANDY SPRING, MD 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GEORGETOWN MED. SCH.4/10/00 WASHINGTON, D.C. 4 ☑ Donation 5 ☐ Other (Specify) 21. Signati 22. Name and Address of Facility USTIN ROYSTER 21 14TH ST. R FUNERAL HOME N.W. WASH, DC. 20011 o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? been signed by the should be detech 1 Yes 2 No 3 Probably 4 Onknown by 24b. Were autopsy findings available prior to Completed 24a. Was an eutopsy completion of cause of death? s certificate has t 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifice completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 R/Outpatient 3 DOA 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

deeth with the Meryland

Baltimore, Maryland 21215-0020

12

Registrar

State

Medical

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner state 29b. Signature and tive of certifier

29c. License number

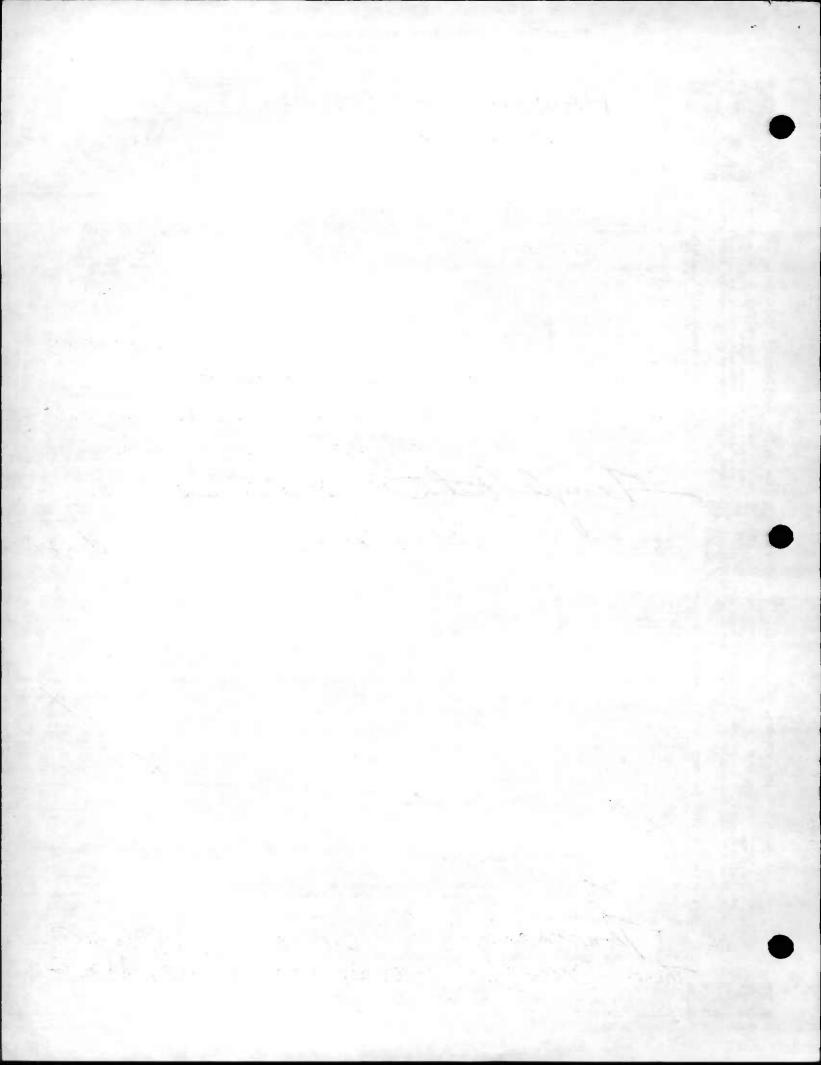
29d. Date signed (Month, Day, Year)

30. Name and address of person of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

19 2000

Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima ot Death Physician 1400 (45 12 Lillian Dosick Snyder April /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Montgomery Alfred House Silver Spring 9. Birthplaca (Stata or Foraign Country) Russia 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Funeral 1□M 2\ F 92 Director 016-36-1377 Usual Rasidanca of Dacedeni with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mentel Hygiene. Important: If Item 27 ie marked other than "natural", or Itema 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinat number to notified at 1€ Yas 2 No Director MD Silver Spring Montgomery 10e. Street and Number 10g, Citizan of What Country? 10f. Zip Coda 20906 U.S.A. 4 Broomall Ct. Funeral 12. Was Decadant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No If Yes, Give Yaar or Datas: 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3- Widowad 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Public School Teacher 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Unknown Dosick Shamitz Unknown 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Print) 5503 16th St., NW, Washington, DC 20011 Ellen Levy/ daughter 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Apr. 16, 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Sharon Memorial Park Sharon, MA 4 ☐ Donation 5 ☐ Othar (Specify) 2000 21. Signatura of Funaral Sarvice Licensee 22. Name end Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical acule CVA Immediata Causa (Final Sudda diseese or condition resulting in death) Examiner Dua to (or es a consequence ot): Examiner Sudden Ly ho Vensuer physician end the burial-transit Sequantially list conditions, if any, laading to immadiata cause. Entar Undarfying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence ot): bullen malmeturtur certificate be Physician/Medical Dua to (or as a consequanca ot): how Offer as Selvis for use as ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contributa to the causa of death? Wellerlites signed by t 1 Yes 2 No 3 Probably Wunknown Division of Vital Records, þ 24a. Was an autopsy performed? 24b. Ware autopsy tindings available prior to Completed Deen complation of causa of death? 2200 1 Yas ZU No 1 ☐ Yas 25. Was casa rafarred to medical axaminar? funeral director, Be 26. Placa of Death (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 ☐ Yas 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27 Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: al or Attending P s efter deeth. I Director: After i d in by the funer 5 Panding invastigation 1 X Natural 1 Yas 2 No 2 Accidant 6 Could not be 3 Suicida 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicida Hospital c To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to tha ceuse(s) end mennar as statad.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Cartifia edicai (Check only one) 29b Signatura and titla of certified 29c. Licanse number 29d. Data signad (Month, Day, Year) (auless his Oluer 725410 13.2000 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Pr. Phillip Dr. Olney MD. LAWLESS OLIVER 810

**DHMH 16 Rev 6/95** 

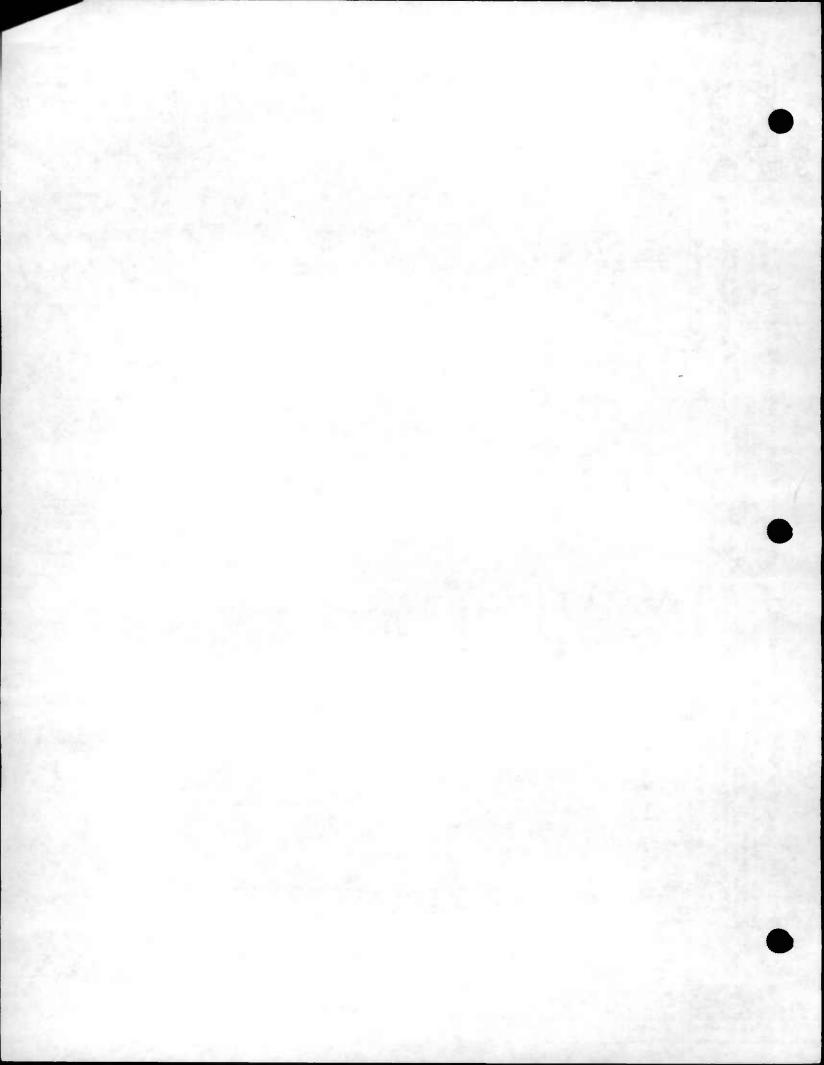
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Registrar

31. Data tiled (Month, Day, Year)

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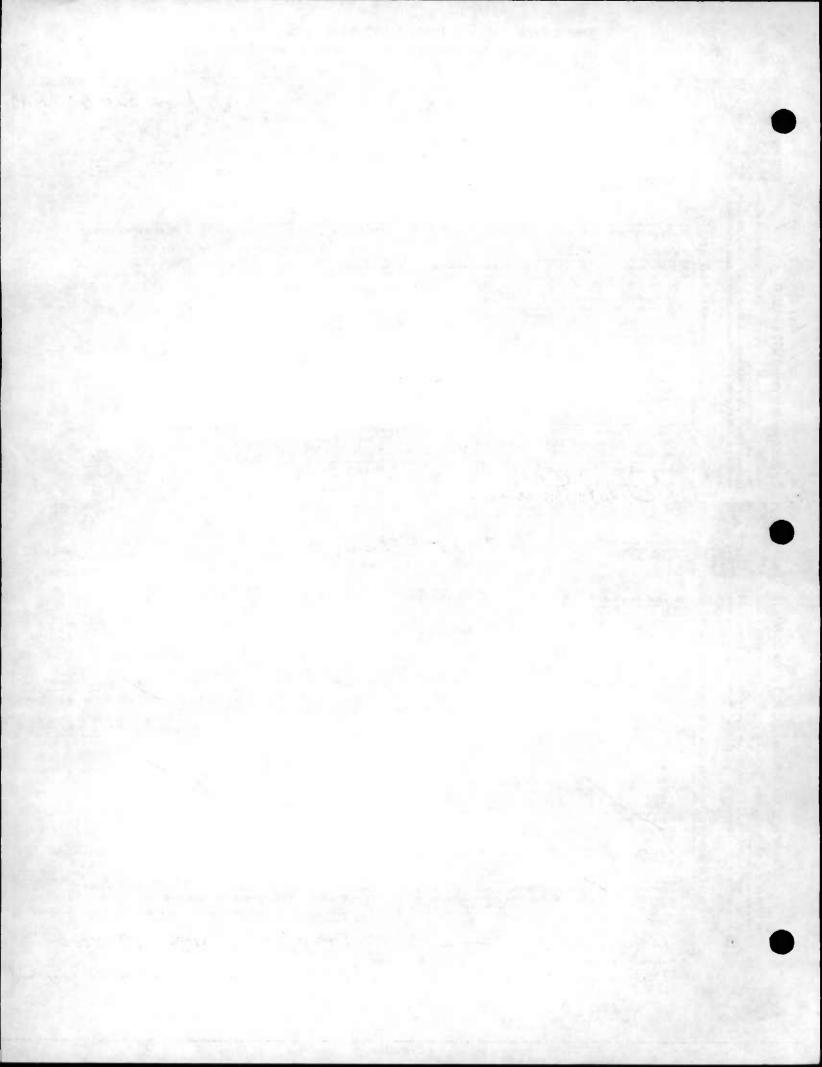
32. Registrar's Signatura



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eral ctor	0	Social Security I	6010	6. Sex 1 □	M 20 F	Age (In yrs. 89	last birthdey Yrs.	Months	er 1 Year Days	If Under 24 Hr. Hours Mir	8. Date of (Month) Jan.	of Birth th, Dey, Yeer) 29,1911 9. Birthplace (State Country), Maryland			lace (State or Foreig try) yland	
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9		CAFA Stephen D. Lohrmann P.A.											MD 21206			
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### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Afr. Year 1 mit Lous -YA WOUD 240 Pm 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Lorien Nursing and Rehabilitation Center Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov.19,1920 9. Birthplace (State or Foreign Country) North Carolina 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days XXM 2DF 79 Yrs. 239-12-7527 Usuel Residence of Decedent 10a. Slele 10b. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City Maryland Howard 1 Yes 2(No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6288 Woodcrest Drive 21043 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1∑Offes 2 □ No if Yes, Give Yeer or Deles: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3℃Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) United States Elementery/Secondary (0-12) College (1-4or 5+) Planning and Estimator Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph W. Smith Zada Simmons 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Hallibut Place Waldorf, Maryland 20603 James R. Phifer (step-son) 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremetion 3 Removel from Stele 4/19/2000 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate Interval Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 20 No 1 ☐ Yes 2N No 1 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dele of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending 1 TYes 2 No investigation

The lew requires that the deeth certificete be executed P.O. Box 68760. Records. Division of Vital

physicien end is the burial-transit ed by the e Sign Dec page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

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State

Registrar

**Funeral** 

Director

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permit. Pages 1 and 2 should be field Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumstic event and any injury or other traumstic event and any injury or other traumstic event

**Physician** 

/Medical Examiner

filed within 72 hours after

Saitimore, Maryland 21215-0020

29e. Certifier (Check only one)

29b. Signeture end total contilier

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stelled.

6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (flem 23a) (Type, Print)

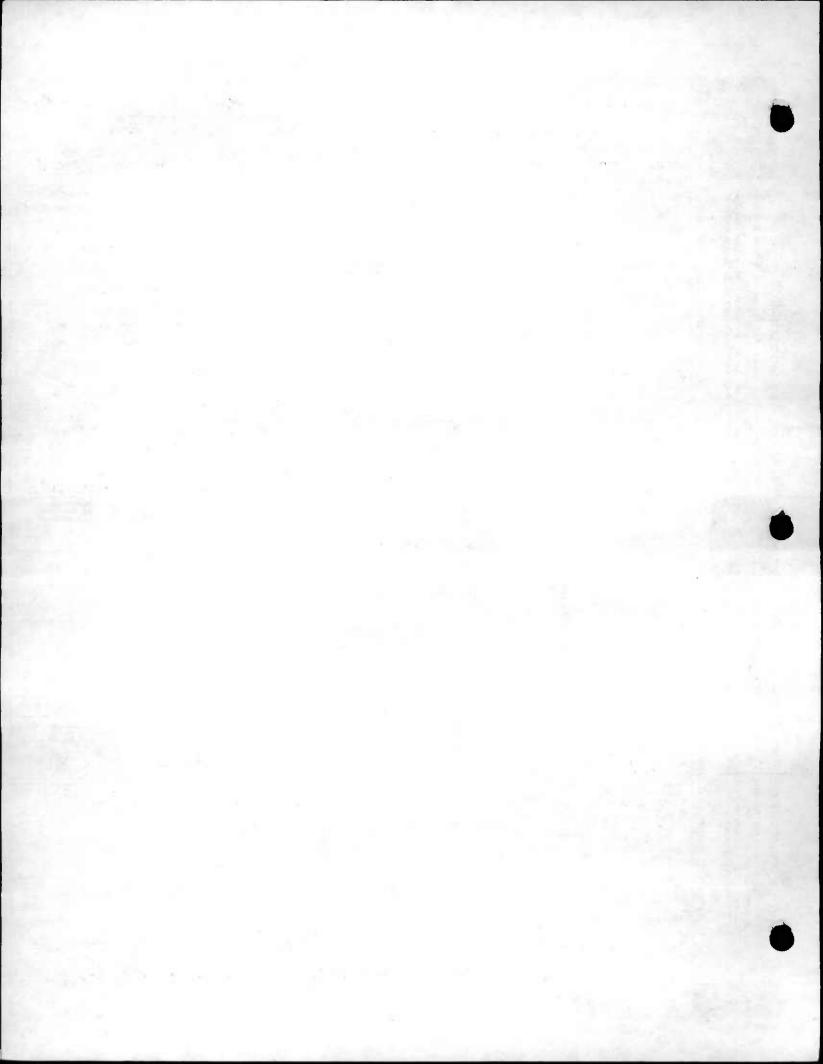
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6-014 31. Dete filed (Month, Dey, Year) APR 20

32. Registrer's Signature

**DHMH 16 Rev 6/95** 

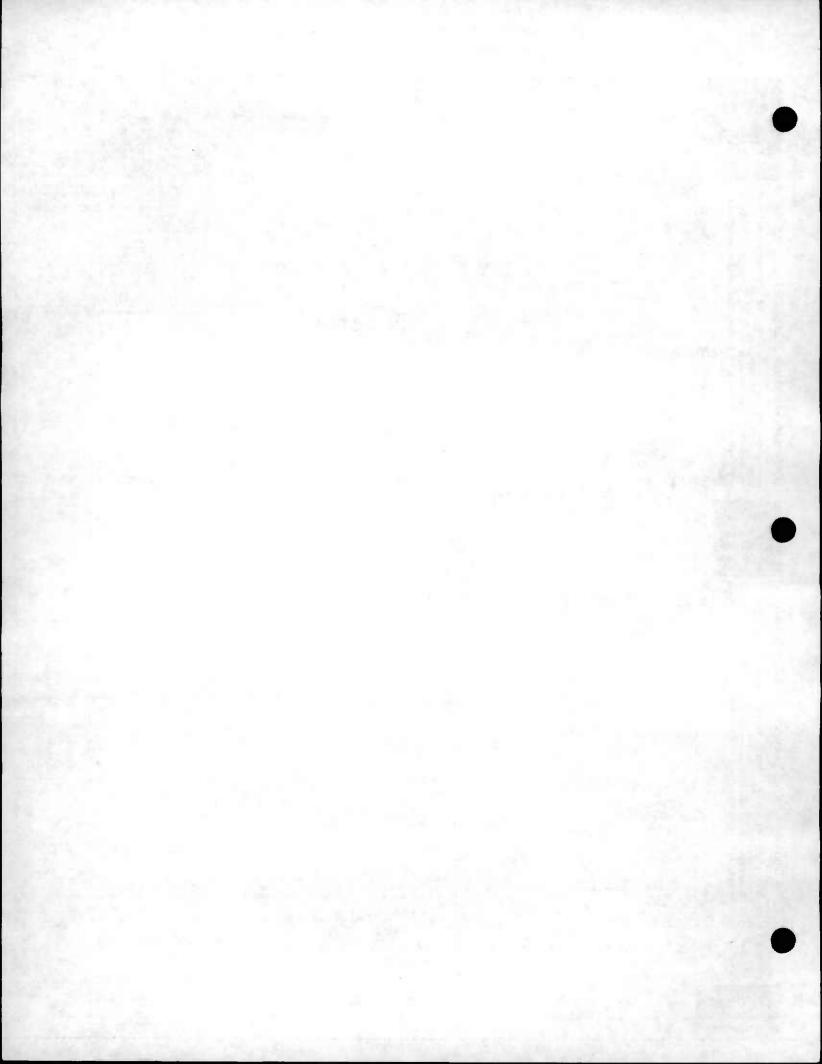
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### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Physician Jean Head Sisco April 20, 2000 9:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chevy Chase 5630 Wisconsin Avenue, #102 Montgomery If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) 9. Birthplece (State or Foreign Country) **Funeral** Days Hours Min. Months 1□ M 2XF Director July 24, Texas 1925 406-22-6862 Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23a or 28a-f show the Missical Examinar must be notified at Yes 2 No Director Maryland Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5630 Wisconsin Avenue, #102 20815 Funeral United States 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Peges 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. International Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed wit Depertment of Health and Mentel Hygiene Important: if ifam 27 ie marked other tha eny injury or other traumatic event, the 5+ Partner Management Firm 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 Lillian Murdock Earl Head 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joseph J. Sisco/Husband 5630 Wisconsin Avenue, #102, Chevy Chase, MD 20815 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Apr. 21 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🖔 Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ ethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Puneral Service Like Bethesda-Chevy Chase, Inc. M00803 Bethesda, Maryland 20814-3501 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset end Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Glioblastoma Multiforme 100 Days Examiner Due to (or es a consequence of): lan/Medical Examiner attending physician and for use as the buriai-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): Box 68760. that initieted events resulting in death) Lest Due to (or es e consequence of): Physici P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings Completed 24a. Wes en eutopsy aveilable prior to completion of cause of deeth? performed? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To After this funeral di 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending s after deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. edical complataly 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) certifier 29b. Signature end title g 29c. License number 29d. Date signed (Month, Dey, Year) 10 101 D14253 April 20, 2000 200 dress of per 30. Neme and a son who completed cause of deeth (Item 23e) (Type, Print) Voith, Marjorie M.D. 5480 Wisconsin Avenue, #LL5, Chevy Chase, Maryland 20815 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture \* State APR 2 1 2000 souls Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \* Amend #2,4/17/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dale of Death 2000 Year 3. Time of Deeth Month **Physician** 1230 DEMETRA /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Heritage Harbor Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 6, 1899 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 💢 F 124-36-7821 100 Athens, Greece Yrs Director Usual Rasidence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 200No Director Anne Arundel Annapolis herne 23a or 28a-finer must be notified 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be flied within 72 hours after death with a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exemine. 2700 South Haven Road 21401 US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, Whita, atc. 1 □ Never Merried 2 □ Married 1 □ Yes 2 N No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ă Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) -8-Seamstress Dress Design 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) å Kiriakos Kaloumenou Eleni Filipou 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 28823 Lomo Drive Rancho Palos Verdes, CA 90275 James P. Sideris - Son 20b. Plece of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/00 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Capitol Funeral Service, Inc. 7211 Lee Highway Falls Church, VA 22046 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or poert failure. List only one cause on aech line. Approximete Intarval Between Onset end Deeth **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequance of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ģ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 1 Natural 5 Pending 1 | Yes 2 | No invastigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) B 4 Homicide

P.O. Box 68760, Records. of Vital

physician and a the burlai-transi The law requires that the death certificate be exe be del certificate after death.

Director: After this certifical Division Hospital

the Maryland

Saltimore, Maryland 21215-0020

24 hours a npletely To the Within 2

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifies

Tous 30. Name and address of person who comple

29c. License number 3001 HOSP DI Chevery MD 20785

29d. Date signed (Month, Dey, Year)

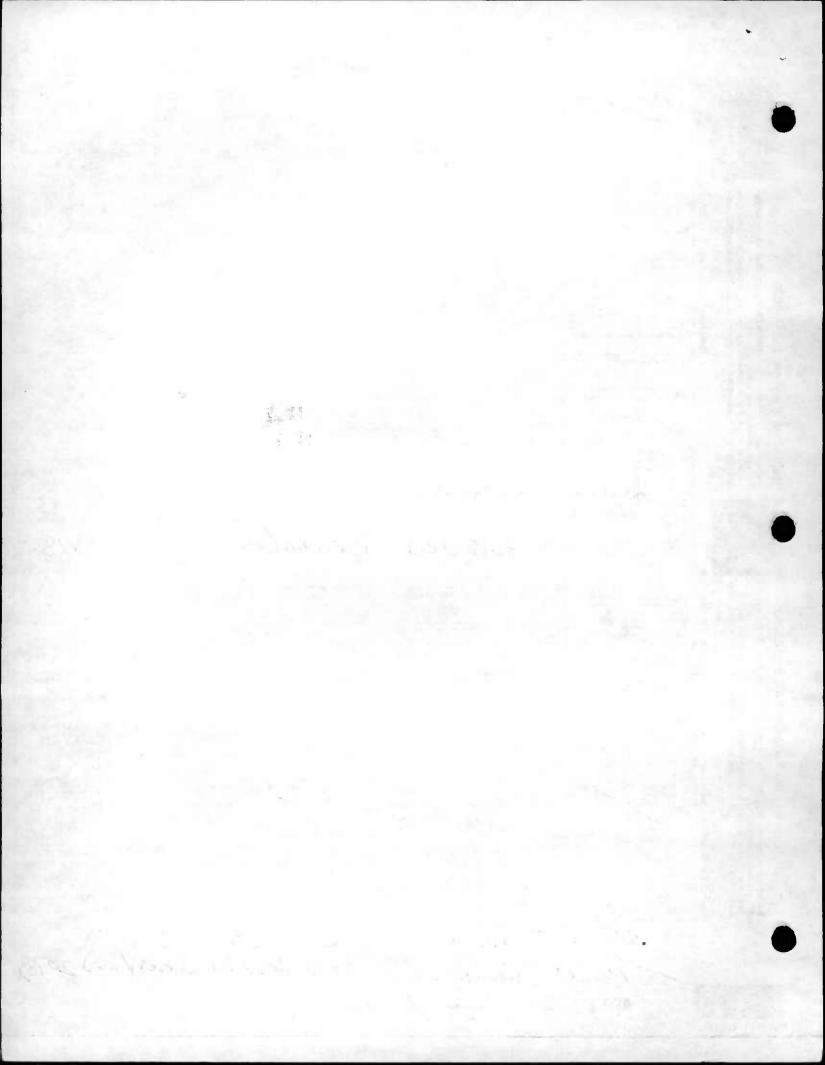
ted cause of death (Item 23a) (Type, Print)

Nadel ava Roli

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et tha time, data end plece, end dua to the ceusa(s)

31. Date filed (Month, Day, Year) **APR 17** 2000 32. Registrar's Signature



Shivers

Shropshire

Kathryne

Month

4b. City, Town, or Location of Deeth

Day

4c. County of Death

April 13, 2000

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

tyFl Yes 2 □ No

Tennessee

White

Bleck, White, etc.

5:10 A.M.

**Physician** /Medical 4a Facility Name (If not institution, give street and number) Examiner **Funeral** Director with the Meryland permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylen Depertment of Health end Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified. Director Funeral Baltimore, Maryland 21215-0020 þ Completed Be

**Physician** /Medical Examiner

the attending physician end hed for use es the buriel-transit the death certificate be executed P.O. Box 68760, datached Š 2 been sig certificate has b After this funerel

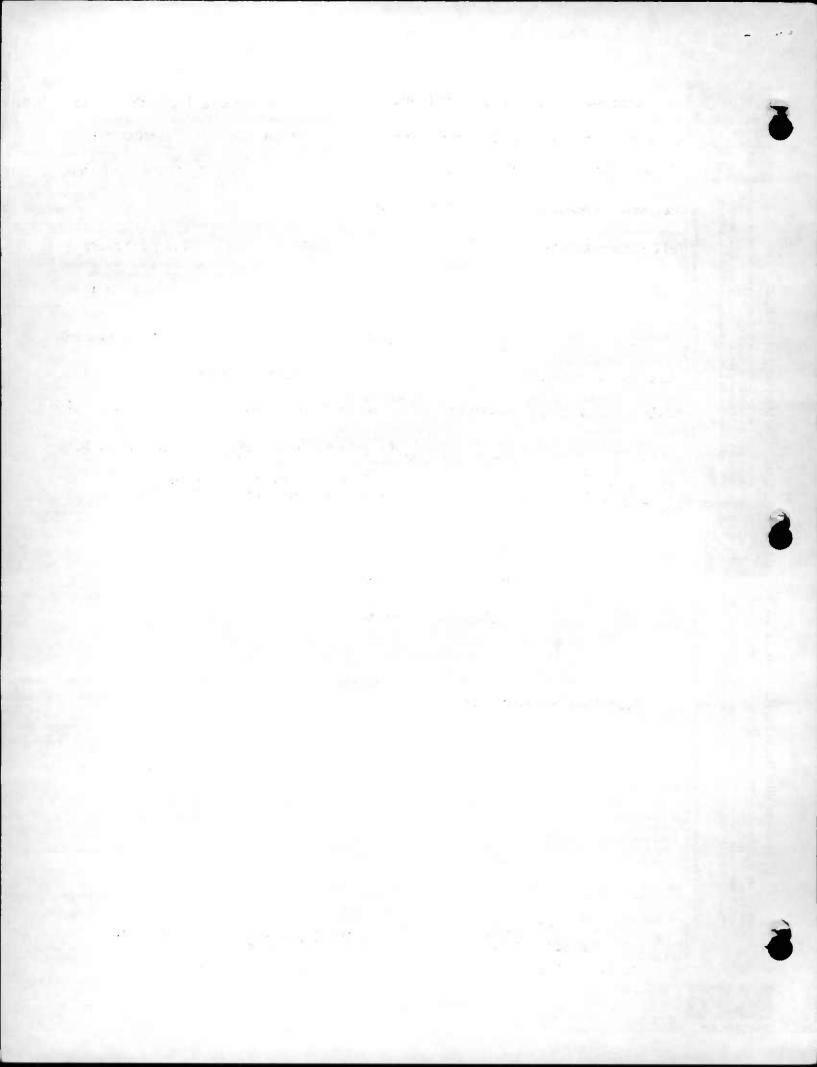
Records,

Division of Vital

Sligo Creek Nursing and Rehabilitation Center Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Months Hours 1 □ M 2/2 F 79 Vrs 415-09-2589 July 23, 1920 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20912 7312 Flower Avenue United States 14. Race - American Indian, 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Esther Gonona Z. Shropshire Ben 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zi 7346 Lee Highway # 202, Falls Church, VA 19e. Informant's Name/Relationship (Type, Print) Randa Rovella Estes/ Daughter 20b. Place of Disposition (Name of cometery, cremetery or other place)
Geo. Wash. University Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Medical Center neral Service Licensi 21. Signature of 22. Name and Address of Fecility 232 Perf 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or es a consequence of): Neurogenic dysphagia Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of) Alzheimers dementia Due to (or as e consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive heart disease 1 ☐ Yes 25. Was cese referred to medical 26. Ptece of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 29c. License number 29b. Signature end title promitie

Zip Code) A 22046 20c. Location - City or Town, State Washington, D.C. Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, DC 20037 Approximate Intervel Between Onset end Death Examiner Physician/Medical 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 2XMIo 1 ☐ Yes 2 ☐ No Attending Physician: Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28d. Describe how injury occurred Certification: ie Hospital or Attending n 24 hours after death. ne Funeral Director: Aft illed in by tha 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical To the To the To the I 29d. Date signed (Month, Day, Year) April 13, 2000 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Norton Elson 6525 Belcrest Road # 208, Hyattsville, MD 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State 2000 1 9 APR Registrar

**DHMH 16 Rev 6/95** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month Yaar MARGARET C. SHIOZAWA 2041 APRIL 12 2000 4a Facility Neme-(If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death SUBURBAN HOSATON GALLARA LARA MORTODMAY 7. Aga (In yrs. last birthday) | If Under 1 Yaar | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Months | Days | Hours | Min. | Max 29, 1919 5. Social Security Number 6. Sex Birthplace (State or Foraign Country) 1□ M 2X F 535-16-3278 Washington Usuel Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6604 Pyle Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? Black, Whita, etc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Merried 1 Yes 2 No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Attorney at Law 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) Kimi Sakai Shinzo Echigoshima 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Bethesda, MD 20817 6604 Pyle Road Sam Shiozawa (Husband) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 04/21/00 Rockville, MD Parklawn Memorial Park 21. Signature of Funeral Service Licensae 22. Name end Address of Fecility JOSEPH GAWLER'S SONS, INC. Honnballer 5130 Wisconsin Ave., NW Washington, 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Daath Immediate Cause (Final diseasa or condition rasulting in death) HEAD INJUNES, ACCIDENT Due to (or as a consequence of): Sequantially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or Injury Dua to (or as a consequence ot) that initiated evants rasulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? FOLLOWING RT. CUNICIE, RT. WRIGH, MUSTIPLE PUBS. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of cause of death? 24a. Wes en eutopsy 1 □ Yas 21 No 2 X No 1 Yas 26. Place of Death (Check only one) examiner? Hospital: 1 Ninpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

attending physicien end for use as the burial-transit MARCARE the funeral director, page 2 should be certificate al or Attending Physician: T s after deeth. Il Director: After this certifical To the Hospital or Atterview within 24 hours after deserted To the Funeral Director completely filled in by the

Be Completed

Medicai

Physician/Medical Examiner Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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**Funeral** 

Director

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ma 23a

permit. Pages 1 and 2 should be filed within 72 hours attar c Department of Heelih and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or han any linjury or other traumatic event, the Medical Examinat

**Physician** 

/Medical Examiner

Maryland 21215-0020

25. Was casa reterred to medical

29a. Certifier (Chark & one)

29b. Signafi

27. Mannar of Death 5 Pending investigation 1 Natural 2 Accident 3 Suicida

4 | Homicide

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NOUL 1,2000

1700 M N 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

SUPPRO OF STANKING I FELL I PLITE

ADDUL 13, 2000

Location (Street and Number or Rural Routa Number, City or Town, Stata) BOTHEROA, MO

1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated. Descripting Physician: 10 life best of my knowledge, dealth occurred at the time, date and place, and due to the cause(s) and mannar stated. re and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

015236

NO

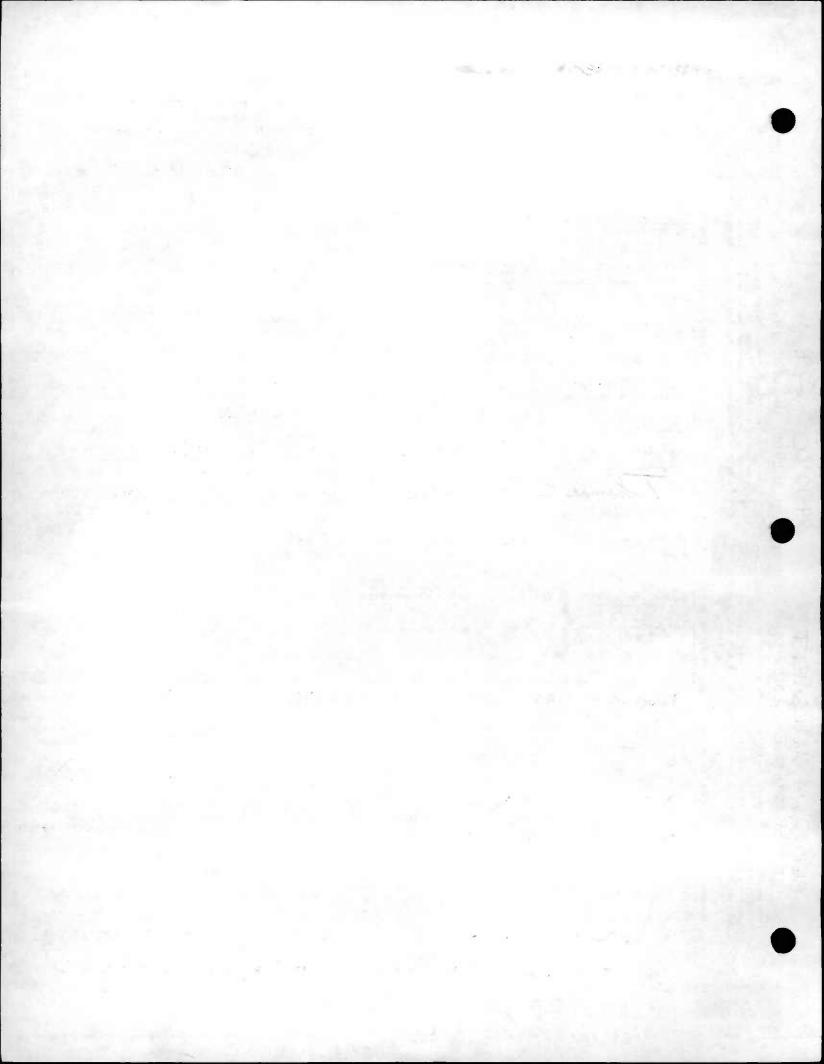
30. Nama and eddress of person who completed causa of death (Item 23a) (Type, Print) I MARGOLIS (NO 10852 31. Data filed (Month, Day, Year)

State Registrar

2000

32. Registrar's Signatura Law

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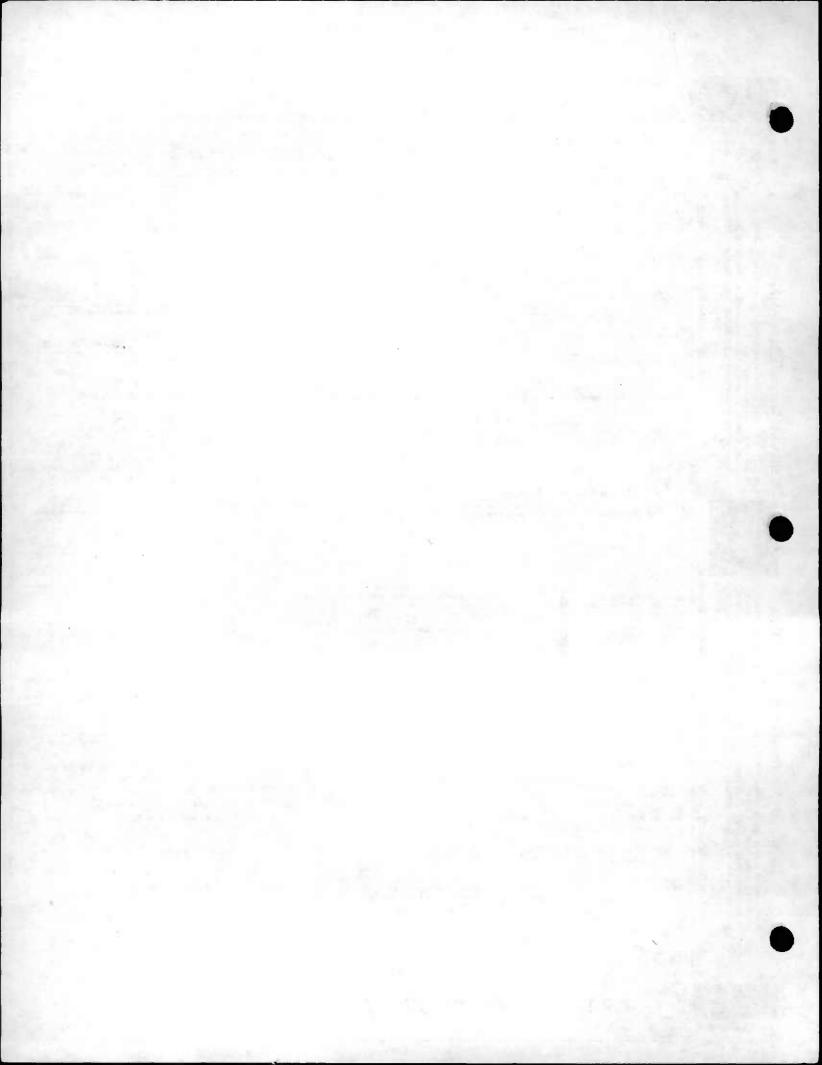


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State of Maryland / Department of Health and Mental Hygiene 1 1,624

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	1. Decedent's Name (First, Mid					2. Date of De Month		Day Year 3. T		of Death		
ysician Medical	Margaret F. S	heehan							11, 20		12	25PM
aminer	4a Facility Name (If not instituti		nber)	9/4		4	4b. City, Town, or					
	SHADY GRO	VE ADVEN	TIST H	HOSPIT	CAL		ROCK	VILLE	MC	ONTGO	MERY	7
eral	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Birt	h			or Foreign
ctor	123-20-6616	1 M 2 M 2 M F	85	Yrs.	MOREIS	Days	HOUIS MINI	Aug. 2			York	
	Usual Residence of Decedent		1.0.00									
Ħ _	10a. State 10b. Count	y, Town or Lo	ocation					10		City Limits		
ct	Maryland Mont	ithersl	ourg						1 KA Ye	s 2 No		
Oire	10e. Street and Number				10f. Zip (	Code			10g. Citizen of	What Count	try?	
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and Mentel Hyglene. Is marked other then "natural", or items 23s or 28s-f show sumstic event, the Medical Examinst must be notified at To Be Completed by Funeral Director	11. Marital Status	,S. 13.	Was Decede	ent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Rad Bla	ce - America				
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d by	3 ☐ Widowed 4 ₺ Divorce						Specia	Whi	te			
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Be	17. Falher's Name (First, Middle	, Last)					18. Mother's Na	me (First, Middle,	Maiden Suman	ne)		
2	John Filson						Sarah H	liscock				
	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address	(Street	and Number or R	ural Route Numbe	er, City or Town	State, Zip	Code)	
ToB	O. Marie Henry	/Friend		9408	Winte	erse	t Drive,	Potomac	, Maryl	and	2085	4
	20a. Method of Disposition		-	Place of Dispo	sition (Name	e of her plea	09)	Apr. 14	20c. Location	- City or To	wn, Stele	
	4 Donetion 5 Other (			teomerv	Cremat	tori	um, Inc.		Bethes	da. Ma	arv1a	nd
	21. Signature of Foneral Service	Licensee	1.201.	22	2. Name and	Addre	ss of Facility Ro	bert A.	Pumphre	y Fun	neral	Home
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	23a Part1 Enter the disease	or complications that or	P10 (	Do not ent	ockv11	LIE,	Marylan	c or respiratory a	7-2003	1	Approxim	ata
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Examiner		b				_						
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edical	resulting in death) Last		Due to (or	r as a conseq	juence of):							
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Physician/	Pert II. Other significant condit	ulting in the u	nderlying ca	iuse giv	en in Part I.		23b. Did tobacco use contribute to the c					
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2	1 Yes 2 No	ER/Outpatier			4 LI Nursing F	Home 5 ☐ Resid	ne 5 Residence 6 Other (Specify)					
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Ē	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	ome, larm, str	eet, factory,	office			ocation (Street and Number or Rural Route Number, city or Town, State)					
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2	29b. Signature and title of certifi	er					e number		29d. Date signe	Month, E	Jay, Year)	,
	Muc				D	38	847		04/11	100		
	30. Name and address of person	who completed cause	e of death (Item	23a) (Type,	Print)					1		
	David Kline,	M.D. 990	Medic	al Cen	ter Dr	rive	, Rockvi	ille. Mai	ryland	20850	)	
tate	31. Date liled (Month, Day, Year	32.	egistrar's Signa		,		,	,	-			
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DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month' Year ( Raymond Samuel Tracy, Sr. 208 20 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Washington County Hospital Hagerstown Washington H Under 24 Hrs. 8. Date of Birth (Month, Pey, Year) 9. Birthplaca (Stete Country) April 4, 1914 Maryland If Under 1 Year 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) \*□ M 2□ F Months Days 215-14-2887 86 Yrs. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Ves 2□No Washington Hagerstown 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code USA 21740 430 Jefferson Street 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 No If Yes, Give 1936-1939 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Tool & Die Maker Private Industry 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Bessie Mary Hose George W. Tracy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 430 Jefferson Street Hagerstown, MD 21740 Raymond S. Tracy, Jr. / son 20b. Pleca of Disposition (Name of cemetery, cremetery or other plece) Rest Haven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremetion 3 □ Removel from Stete 4-25-00 Hagerstown, MD 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 Approximete Intervel Between Onset end Death my that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest Central Carolin Rogeling 1 deteck Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveitable prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Diffeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Desturel

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Nem 27 is marked othe any injury or other traumatic sound.

filed within 72 hours after

Saltimore, Maryland 21215-0020

nding physicien end use as the buriel-trans pege 2 should be certificate After this 24 hours after deat Funeral Director:

Physician/Medical Examiner ģ Completed Attanding Physician: Be Medical Certification: To death.

Vital Records, P.O. Box 68760,

, Kaymor Samue

State Registrar

5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number

of person who completed cause of death (Item 23a) (Type, Ppin)

29d. Dete signed (Month, Dey, Year)

31. Dete filed (Month, Dey, Year) APR 2 4 2000

3 ☐ Suicide

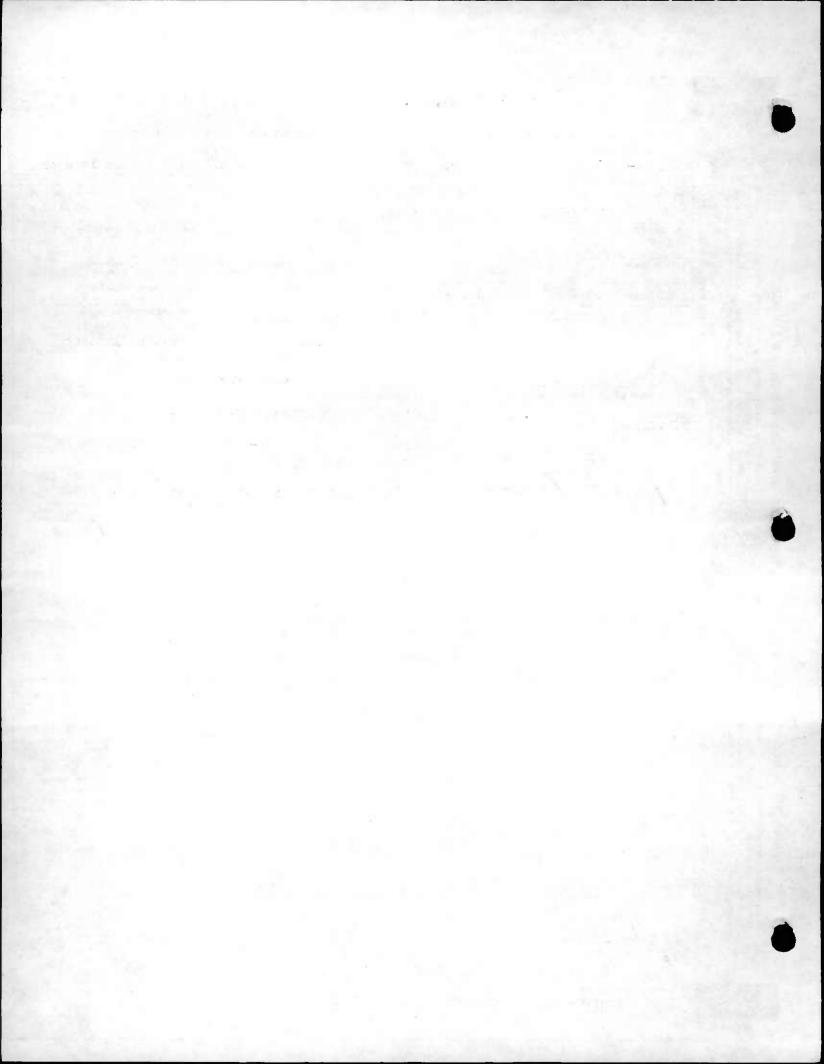
29a. Certifier (Check only one)

29b. Signature

32. Registrer's Signeture

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To the I



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Mamie Viola TURNER April 20, 2000 12:30a.m. /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coffman Nursing Home | Nage | Brith | H Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | Feb. 15,1907 Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2⊠ F 216-22-8281 Yrs 93 Director Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits id 2 should be ilied within 72 hours after deeth with the Maryler lith end Mentel Hygiene. 77 Is marked other than "natural", or items 23e or 28e-f show trainmatic avant, the Medical Examination and by notified as 1⊠Yes 2□No Director Maryland Washington Hagerstown 10e. Street end Number 10/. Zip Code 10g. Citizen of What Country? 11 W. Baltimore Street #416 21740 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ white 3₺ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) sales manager retail clothing store 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be l and 2 should be Edward Cook Flora Delosier 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pegas 1 and 2: Department of Health e Important: If item 27 is any injury or other trau Jane Anderson - daughter 145 Maple Hill Dr., Etters, Pa. 17319 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland 4-4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 21. Signature of Europa Service Licensee 22. Neme and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) 48 hrs. acute right cerebral hemisphere infarction Examiner Due to (or as a consequence of): Examiner the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) requires that the death certificate be Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Previous stroke hypertension þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy pege 2 should Completed carcinoma of breast, coronary artery disease The law r osteoporosis, gastroesophageal reflux disease 1 Yes 2 XNo 1∏Yes 2∏No certificate Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Naturel 1 Yes 2 No death. 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide 6 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) 29a. Certifier Medical (Check only one)

Division of 24 hours Hospital To the Hosp within 24 hou To the Fune completely fi

> State Registrar

29b. Signeture end title of certifier

31. Date filed (Month, Dey, Year) 32. Registrer's Signeture APR 2 4 2000

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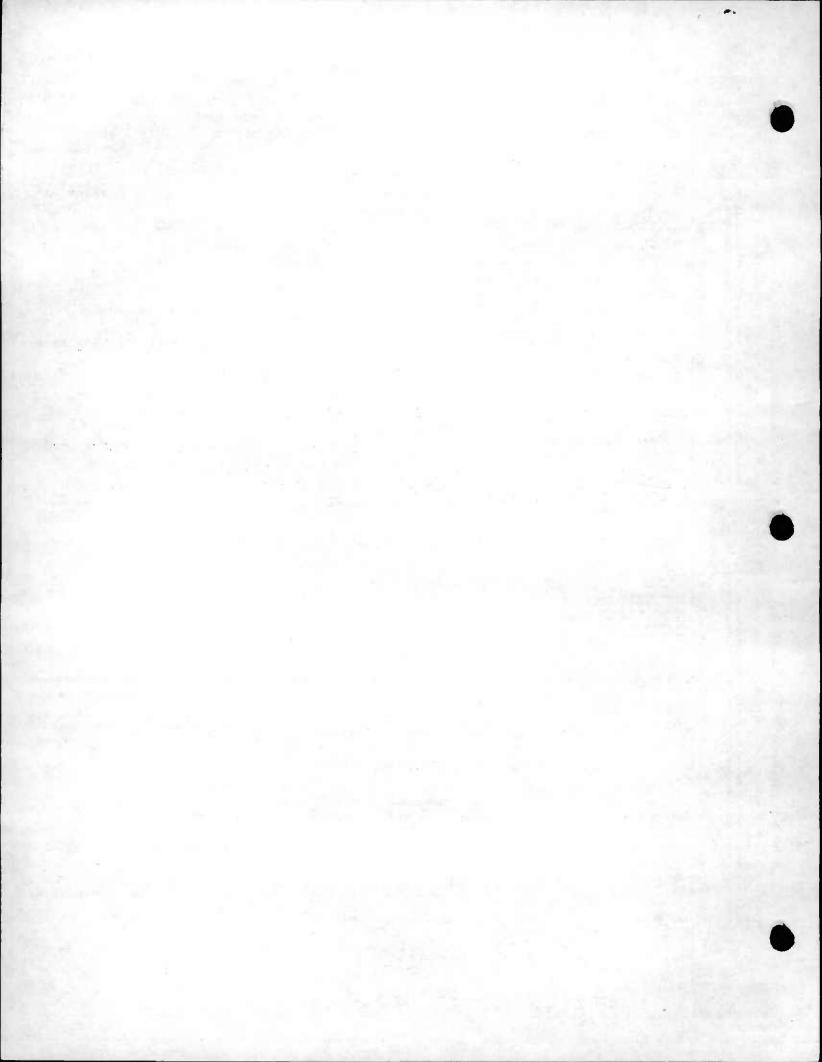
30. Name end eddress of person who completed pause of deeth (Item 23a) (Type, Print)
Dr. Edson B. Moody, 1190 Mt. Aetna Road, Hagerstown, Maryland 21740

29c. License number

D07857

29d. Date signed (Month, Day, Year)

4/18/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Herschel Harp Thurmond 23, 2000 4c. County of Deeth April /Medical 9:30 A.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Colton Villa Nursing Center Hagerstown Washington If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland Funeral 1₽M 2□F Months. Days 214-09-6599 Director 90 Sept. 16. 1909 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Washington X☐ Yes 2☐ No Md. Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 145 King St. 21740 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exercises once. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Repairman Utility 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard C. Thurmond Adah Blanche Harp 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Markwood L. Thurmond (Brother) 245 Devonshire Rd. Hagerstown, Md. 21740 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Ap Pate 24. 20c. Location - City or Town, State Smithsburg Crematory Smithsburg, Md. Donation 5 ☐ Other (Specify) Signature of Futeral Service Licensee 22. Name end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physiclan** Immediate Ceuse (Finel disease or condition resulting In death) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner De Men 7/A 2 years Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Records, P.O. Box 68760, that the death certificate be 9 Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco uee contribute to the cause of deeth? 3 □ Probably Unknown 1 ☐ Yee 2 ☐ No nare þ 24b. Were eutopsy findings evelleble prior to Be Completed 24a. Wes en eutopsy performed? completion of ceuse of death? The law 1 ☐ Yes 2 No 1 Yes Division of Vital 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one)

Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 1 Yes 2 No this 27. Menger of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Affler or Attending 5 Pending investigation 1 Naturel desth. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner steted. Medical 29a, Certifier 29b. Signature and title of certifier

29c. License number

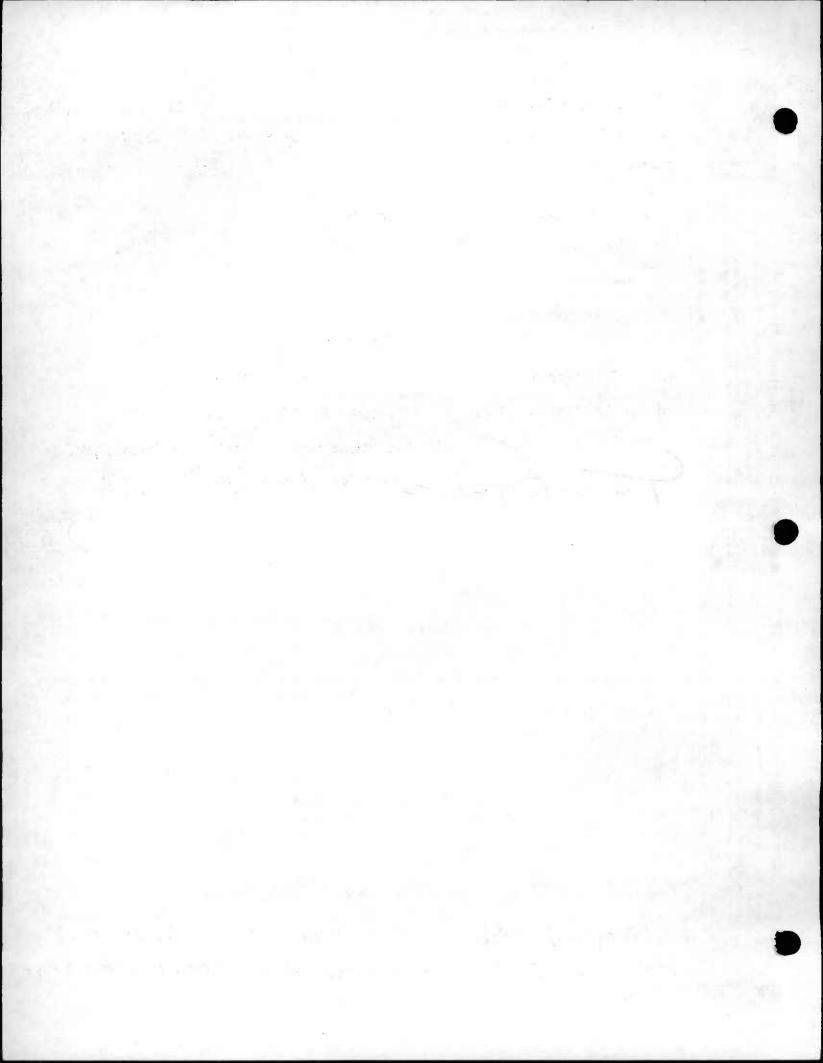
of person who completed cause of deeth (Item 23e) (Type, Print)

D28365-

368 Mill Stral Hagustenn 19 D 21740.

29d. Date signed (Month, Dey, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Charles Joseph Trunnell April 18 2000 10 30 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Calvert Solomons Nursing Center Solomons r | If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Jan 8 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ★**□ M 2□ F Washington D¢ Yrs 86 Director 577 14 7450 Usuel Residence of Deceden the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits y□Yes 2□No Director 288-1 Maryland Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? ò 20732 8226 Bayside Road 238 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after togestranent of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any injury or other trauments event, the Medical Event 1 Never Merried 2 Married 1 Yes 2 No It Yes, Give Yeer or Detes: 45 - 46 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) plumbing plumber 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) unknown unknown 19a. Informant's Name/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Eileen M. Bradfield-friend 8226 Bayside Rd. Chesapeake Beach MD 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State
 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Rausch Funeral Home PA P.O. Box 100 Owings Maryland 20736 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. **Physician** /Medical fmmediete Ceuse (Final diseese or condition resulting in death) WLOSE PSIS Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest and Due to (or es e consequence of): P.O. Box 68760, Due to (or es e consequença of) Pert If. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Aithrit 1 Yes 2 XNo 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending Investigation 1 Offaturel after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the fours at To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es stated.

| Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29b. Signature and title of cartile

Registrar

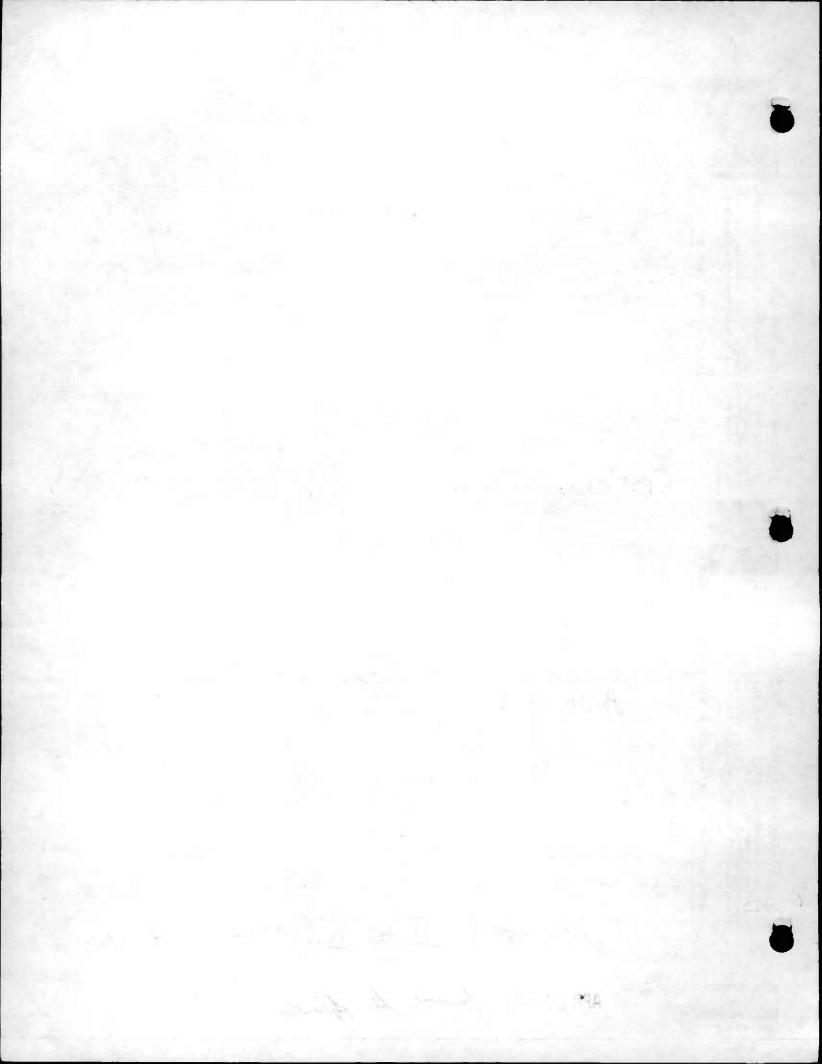
State

John Barth III M.D. Prince Frederick MD 20678

32. Registrer's Signeture

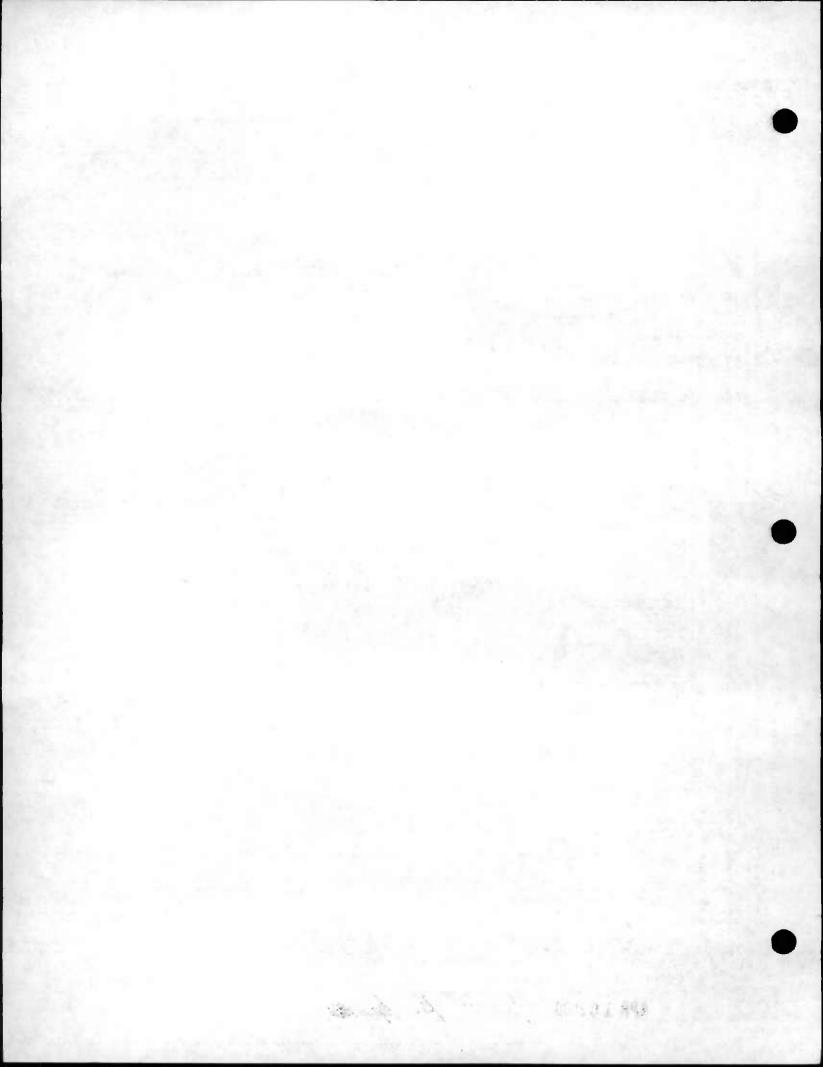
30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2000



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

			e of Maryi		rtificate of	Health and Death		Reg. No.		629
Physician	Decedent's Nama (First, N	fiddia, Last)					2. Data of De Month		Yaar	3. Tima of Death
/Medical	James Peery	Thomas,	Jr.				April	14,2000		9:00 P.M.
aminer	4a Facility Nama (If not instit 9531 Acom Pa.	=	d number)			4b. City, Town, or Capitol I				orge's
ral tor	5. Social Security Number 226–54–1567	6. Sax 1 <b>∑</b> M 2□		rs. last birthday, 56 Yrs.	Months Days			v. Year)	9. Birthpl Count	aca (Stata or Foraign ry) NC
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Funeral Director	MD Prin	ice George	es Ca	pitol H	elghts 10f. Zip Coda			10g. Citizan of N	Mhat Coun	Λ
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era	11. Marital Status		- Dacedant Evar in	n U.S. 13.			Specify Yas or No	USA - 14. Rad	e - Amarica	an Indian,
	1 Nevar Married 2 3 XWidowed 4 Divo	Married 1 Y	d Forcas? as 2 XNo , Give or Datas:		If Yes, specify Cult  1□ Yas 2□ No	Hispanic Origin? (S ban, Mexican, Puer o Specify:	rto Rican, atc.)	Specify	ck, Whita, a	atc.
Completed by		dent's Education	or Datas.	16a Dece	dent's Usual Occu	noation		16b. Kind of B		
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0	James Peery 7	homas, Sr				Margare	t Kellun	1		
-	19a. Informant's Name/Ralat			19b. Mail	ing Address (Stree	at and Number or R			Stata, Zip	Coda)
	Kelly Hottle	/ Daughte	er	13491	Princed	ale Dr. W	oodbrid	ge, VA 2	2193	
	20a. Mathod of Disposition		20	b. Place of Disp	osition (Name of matory or othar pl		Date	20c. Location		wn, State
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	21. Signature of Funaral San	vice Licensaa	10.			rass of Facility Funeral				
	Golfa Mon	tyoney. Ch	eathan	41	11 Penns	ylvania .	Ave. Sui	tland, 1	MD 20	746
Physician/Medical Examiner	Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last	c	Due fo	o (or as a conse	quence of):	omkosis vnscula	r Di	sease		
							1 001 011		1	
Jysi	Part II. Other significant con	0.		rasulting in tha	undariying causa g	iven in Part I.				the cause of death?
	Chronic F	tleaholism		v1			10	Yes 2□ No	3 LI Prot	Debly 4 Unknown
							24a. Was	an autopsy ormad?	cor	ere autopsy findings allabla prior to applation of causa death?
Completed							154	Zes 2□No		Yas 2□ No
	25. Was casa ratarrad to me	dical				26. Place of De	eath (Check only		.,,,,,	
o Be	axaminar? 1€ Yas 2 No	Hospital:	1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3D DOA		Homa 5 ☐ Rasi		ar (Specifi	SCene
Certification: To	27. Manner of Death  1 SNatural 5 Pa 2 Accidant	nding (fastigation	Pata of Injury Month, Day Year	28b. Tima o	of 28c. Inj			how injury occur		, 555115
THE PERSON		termined 28e. P	lace of Injury - A uilding, atc. (Spe	At home, farm, si ecify)	raet, factory, office	•	28f. Location ( City or To	Street and Numi wn, Stata)	ber or Aura	l Routa Number,
edical C	29a. Certifiar (Check only one)	ifying Physician: To icat Examiner: On the	the best of my lina basis of axam mannar statad.	knowledge, dear nination and/or Ir	th occurred at than	tima, data and plac opinion, death occ	e, and due to the curred at the tima,	cause(s) and m data and placa,	anner as st and due to	ated. tha cause(s)
M	29b. Signature and title of ce	rtifier		200		nse number		29d. Data signa		
	1 /Year	-1/1	ut		0.C.	M.E.		April 1	15,200	00
/	30. Nama and addrass of per	son who complated	causa of daath (	Itam 23a) (Type	, Print)			-, - 19		
	Dennis J.	Chute	Clarefulli-1-			Donn Ct-	oot Bal	timoro	M	land 21201
ate	31. Data filed (Month, Day, Y	ear) 3	2. Registrar's Si	ignatura	/	Telli SUP	eet, Bal	thiore,	rially.	land 21201
istrar	APR 197	2000	Sy body	Ø. ,	San Asi	•				



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State of Maryland / Department of Health and Mental Hygienen

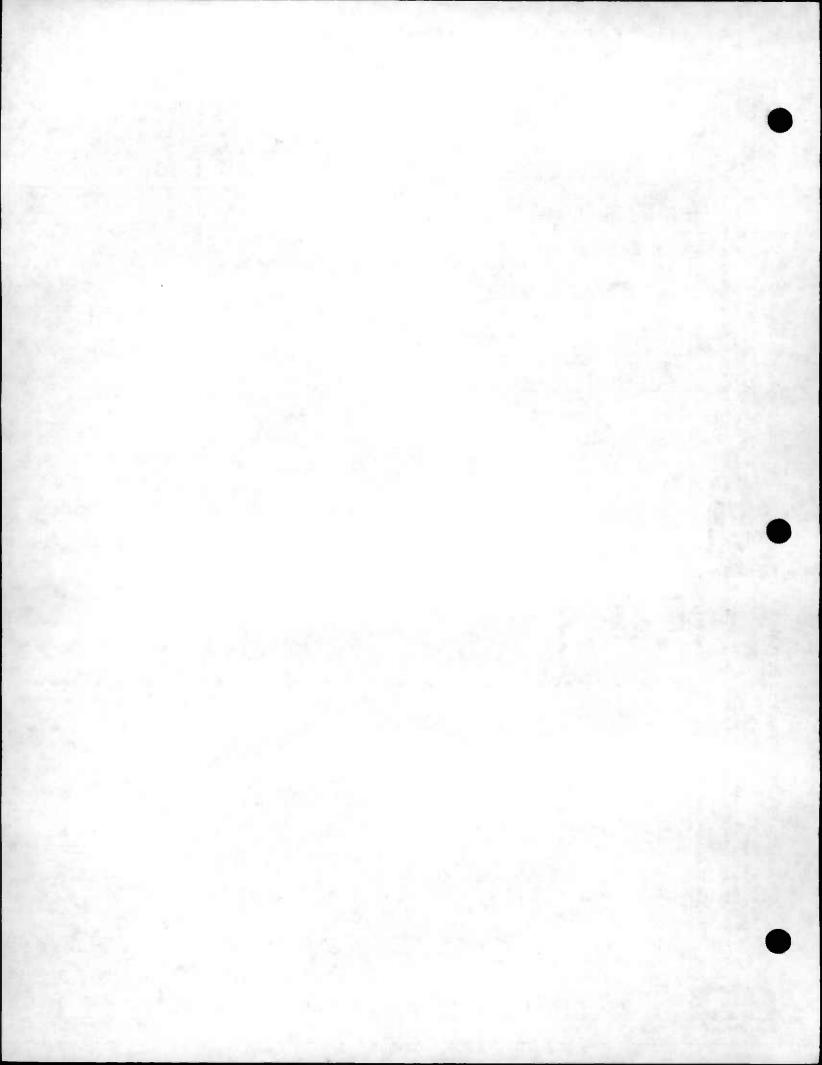
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Physician Rosalie Virginia Tomasso 20, 2000 April 8:45AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Deys Hours 1□M 2XF Yrs. 144-10-5782 82 Director Feb. 13, 1918 New Jersey Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Merylen Department of Health and Mental Hygiene. Important: If item 27 is merked other than "neturel", or items 23s or 28s-f show any injury or other traumstic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Montgomery Potomac 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 10718 Potomac Tennis Lane 20854 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕅 No If Yes, Give Year or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 8 Charles Wesley Westcott 2 Nellie Naylor 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) Donald C. Tomasso-Son 13145 Scarlet Oak Dr., Darnestown, MD 20878 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, State Dete April 24, 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Vineland, 4 ☐ Donetion 5 ☐ Othar (Specify) Siloam Cemetery 2000 New Jersey 22. Name and Address of Fecility
Robert A. Pumphrey, Funeral Home/Bethesda-Chevy
Chase Inc. MD/20814-3501 21. Signature of Funeral M01126 23a. Part1. Enter the diseesa, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or raspiretory errest, shock, or heart failure. List only ona cause on each line. Approximata Intarval Batween Onset end Death **Physician** /Medical Immediate Ceuse (Final years disease or condition resulting in death) Examiner Examiner physicien and s the buriel-transit certificate be executed Sequantially list conditions, if eny, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initieted events rasulting in deeth) Lest Due to (or es a consequence of). Box 68760. edical Due to (or es e consequence of): ettending Physician/M nse 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. the signed by to 1 Yes 2 No 3 Probably 4 Unknown à The law requires 24b. Were eutopsy findings available prior to complation of causa of deeth? 24a. Wes en eutopsy performed? Completed peen page 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yas 2 📉 No this funeral 27. Mennar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 1 X Naturel 5 Pending investigation Injury after death.

Diractor: Aft
d in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Streat end Numbar or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital o within 24 hours aft To the Funeral Di completaly filled in 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and menner stated. edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 10038781 0 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 4910 Massachusetts Avenue, N.W., Washington, D.C. 20016-4300 Michael J. Grady, M.D. 31. Data filed (Month Day, Year) 2000 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

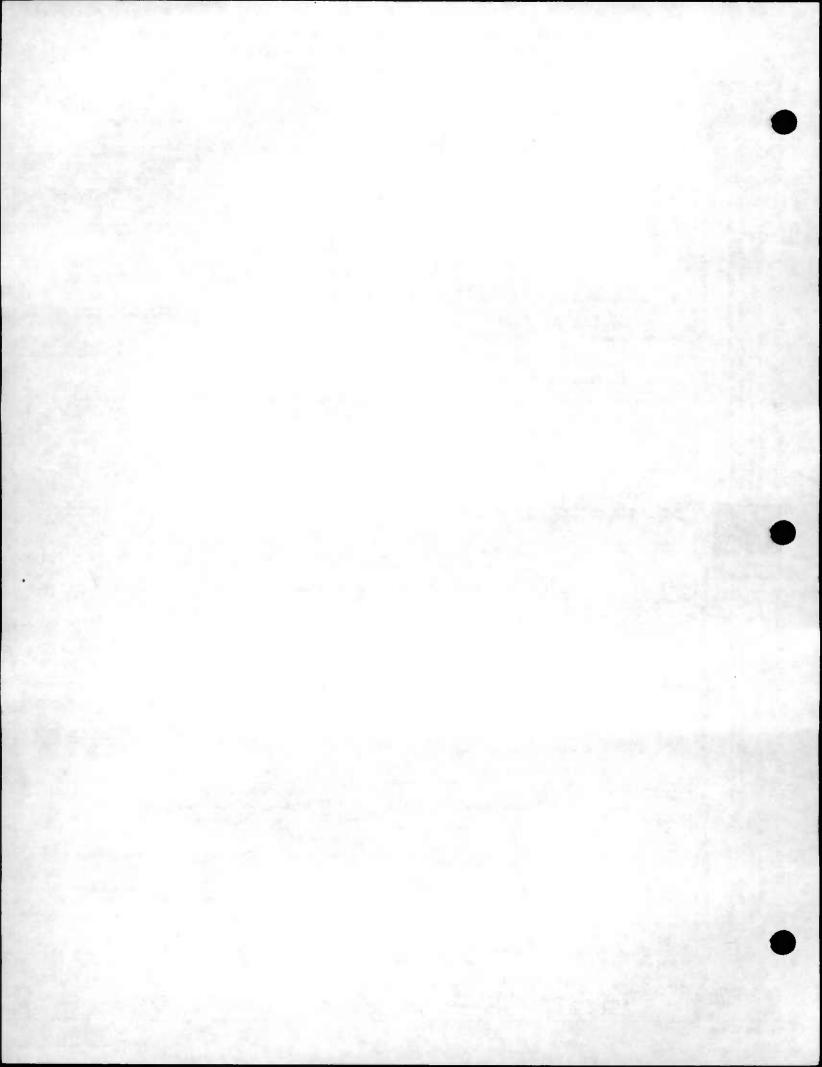
Registrar



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State of Maryland / Department of Health and Mental Hygiene 0 1463

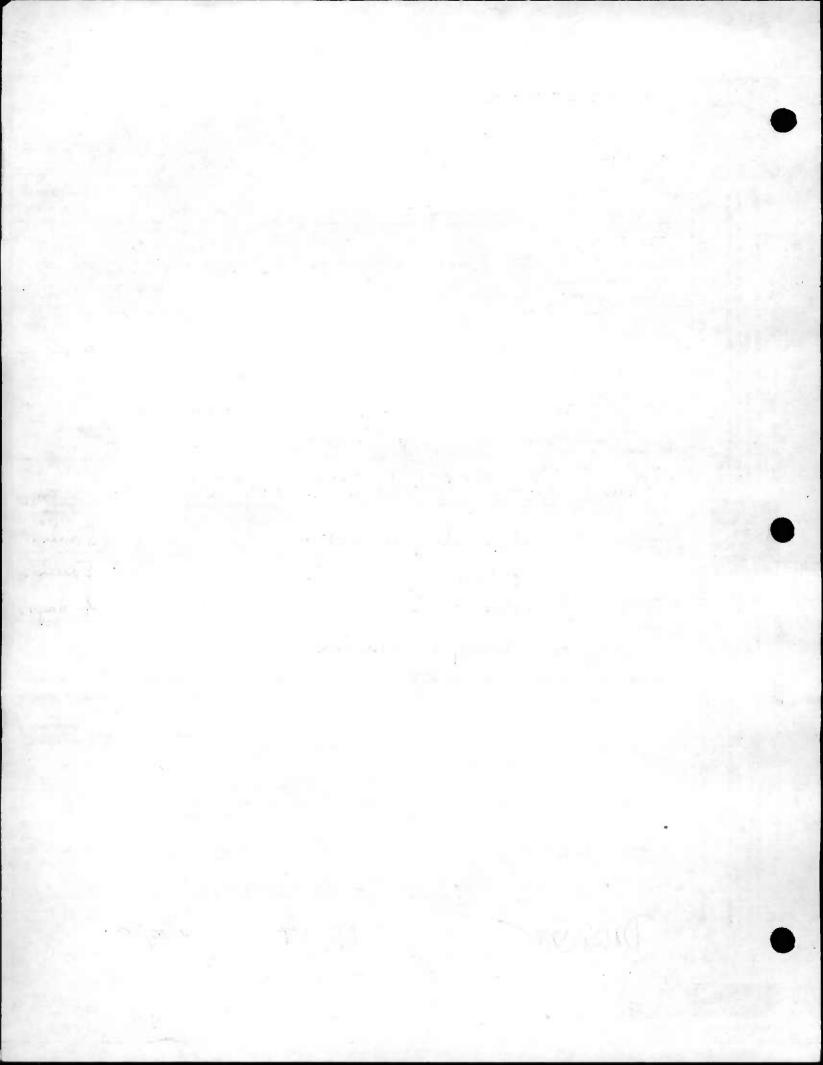
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Physician	1. Decedent's Name (First, Middle, Last	ot)				2. Data of Daat Month		3. Tima of Death
/Medical	Christine		V	rompe	NO	April	11 20	
Examiner	4a Facility Name (If not institution, give	street and number)	11	1.1	4b. City, Town, or	Location of Death	4c. County of	Death
	5. Social Security Number 6. Se	HODICINS	(In yrs. last birthda	If Under 1 Ya	ar If Under 24 Hrs	ore City		Birthulana (State or Foreign
Funeral Director	228-54-3533	D.4 .D.	60 Yrs.	Months Day			, 1939	Birthplaca (State or Foreign Country) Virginia
3	Usual Residence of Decedent  10a. State 10b. County		IOc. City, Town or	Location				10d. Inside City Limits
of a Po	VA Fauquier	:	Warrent	on				1 ☐ Yes 2 🖔 No
"natural", or Nama 23a or 23a-f ahow adoal Examinat must be notified at leted by Funeral Director	10e. Street and Number 7208 Mecklenburg	Drive		10f. Zip Code		1	0g. Citizen of Who	et Country?
ma 2;	11. Marital Status	12. Was Decedent Ev	er in U,S. 13	. Was Decedent of	of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No-	14. Race -	American Indien,
it, or he	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ( ) Yes If Yes, Give Year or Dates:		If Yes, specify C		rto Rican, etc.)	Specify:	White, etc. Black
ted ted	15. Decedent's Edu	ucation	16a. Dec	edent's Usual Occ	cupation		16b. Kind of Busin	ness/Industry
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Contract	11		S	ecretary				Government
Be very	17. Father's Neme (First, Middle, Last)					me (First, Middle, I		
To To	Lofton Lambert	Cara and Kar				e Strothe		
er traum	19a. Informant's Name/Relationship (T) Thomas E. Thompso				eet and Number or F Mecklenbu			n, VA 20187
Important: If fem 27 is marked other than any injury or other traumatic event, the Monte.	20a. Method of Disposition  1 ABurial 2 Cremation 3 F  4 Donation 5 Other (Specify)		cametery, cr	positi <i>on (N</i> eme of ematory or other) t Valley	olaca) Cemetery		20c. Location - Ci Hamilto	n, Virginia
Departm Importar any Inju	21. Signature of Funeral Servica Licens		. 6 1 1	-	dress of Facility uneral Ho		774 2010	0
	232 Port Folly the disease or order	0000		P.O. box		rrenton,		Approximate
	23a. Part 1. Enler the disease, or como shock, or leart failure. List only o	one cause on each line		inter the mode of t	Jying, Socii as Cardie	ic or respiratory arm	651,	Interval Between Onset and Death
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should should						24a. Was a perform		24b. Were autopsy finding available prior to completion of cause of death?
ge 2						4 FT V	es 2 No	1 ☐ Yes 2 ☒ No
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ficate or, pe	1 25 Was case referred to medical	Hospital:	2 ER/Outpati	ient 3 DOA	Other	eath (Check only on Home 5 Reside	Commence of the second	(Spacify)
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** ALVIN MARTIN WHITBY, SR. April 20,2000 0250 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, giva street and number) 4c. County of Death Examiner The Memorial Hospital Talbot Easton 5. Sociel Security Number 218-30-1939 If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year) 10-04-1934 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F 65 BALTIMORE Yrs. Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at MD Yes 2□No TALBOT Director TRAPPE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 4230 OLD TRAPPE RD 21673 238 U.S.A. Funeral 'natural', or items 12. Wes Decedent Ever in U,S. Armed Forcas? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer a Depertment of Heelth and Mental Hygiane. Important: if Item 27 is marked other than "natural, or Item any injury or other traumetic event, the Medical Essentia 1 ☐ Never Merried 2 Merried Alvin Whitby Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes: 1□ Yes 21 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 INDEPENDENT CONTRACTOR AGRICULTURE 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLARENCE WHITBY MARGARET E. LONG 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GLORIA LEE WHITBY/WIFE 4230 OLD TRAPPE RD, TRAPPE, MD 21673 20b. Plece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State 1 N Buriel 2 □ Cremetion 3 □ Removal from State LANDING NECK CEMETERY 4/22/00 TRAPPE, MD 4 ☐ Donelion 5 ☐ Other (Specify) ure of Funeral Source Ligan 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM aum 200 S. HARRISON ST. EASTON,MD 21601 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betwe Onset and De **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical arrest vatry mun. Examiner Due to (or es e consequence of) Physician/Medical Examiner empolism + use es the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): eniania P.O. Box 68760. thet initieted events rasulting in deeth) Lesi Dua to (or as a consequence of): accumonia to 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 PYes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were eutopsy findings aveilable prior to completion of cause of death? director, page 2 should Be Completed 24a. Wes an eutopsy 2 1No 1 ☐ Yes 2 ☐ No 1 Yes certificate Division of Vital Hospital or Attending Physician: '24 hours after death.
 Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicida 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) complataly filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) within 2 To the To the 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 100 20 30. Nema and addrass of person who completed causa of daath (Item 23a) (Type, Print) DAVID SMITH, M.D. 29466 PINTAIL DR. EASTON, MD 21601 31. Dala filed (Month, Dey, Year) 32. Registrar's Signetura State APR 2 1 2000 Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Dev JOHN MACARDELL WALTON, SR. 19, 2000 0700 APRIL 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 32316 COVEY'S LANDING ROAD CORDOVA TALBOT If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) Deys Hours 1X M 2□ F Yrs. JULY 2, 1912 MARYLAND 220-32-6774 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No **CORDOVA** TALBOT 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 32316 COVEY'S LANDING ROAD 21625 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona duning most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 ARCHITECTURE ARCHITECT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BECHER WILLIAM RANDOLPH WALTON MARY AGNES 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) JOAN M. DENT/ DAUGHTER 32314 COVEY'S LANDING ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremetion 3 Removel from Stete 4-24-00 RESURRECTION CEMETERY CLINTON, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensea 22. Name and Address of Facility 117 F.5. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. kunam 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Batween Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line. Immediate Ceusa (Final diseese or condition resulting in death) Due to (or es e consequenca of) Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Dua to (or as e consequenca of) Due to (or es e consequença of) 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilable prior to . completion of causa of daath? 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner The law requires that the death cartificate be axecuted

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

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MD

**Funeral** 

Director

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permit. Pages 1 and 2 should be illed within 72 hours after topoclarment of Health and Mental Hygiene. Insportant: If Nem 27 is marked other than "natural", or Nes any injury or other traumetic event, the Medical Examinar

Saltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

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g physician and as the burial-transit Examin Physician/Medical attending | n signed by the Completed by director. Be Certification: To After thi within 24 hours after death.

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Pert II. Other significant conditions contributing to death but not rasulting in tha undarlying causa given in Pert I. 25. Wes case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? Neturel 5 Panding 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier Lactifying Physician: To the best of my knowledge, deeth occurrad et the time, date end piece, and due to tha causa(s) and mannar as stated.

State Registrar

Medical

(Check only one)

29b. Signeture end title of cert

JENNIFER HOLLYWOOD, MD 506 IDLEWOOD AVE EASTON, MD 21601 31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

e and eddress of person who completed causa of daath (Item 23a) (Type, Print)

APR 2 0 2000

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stated.

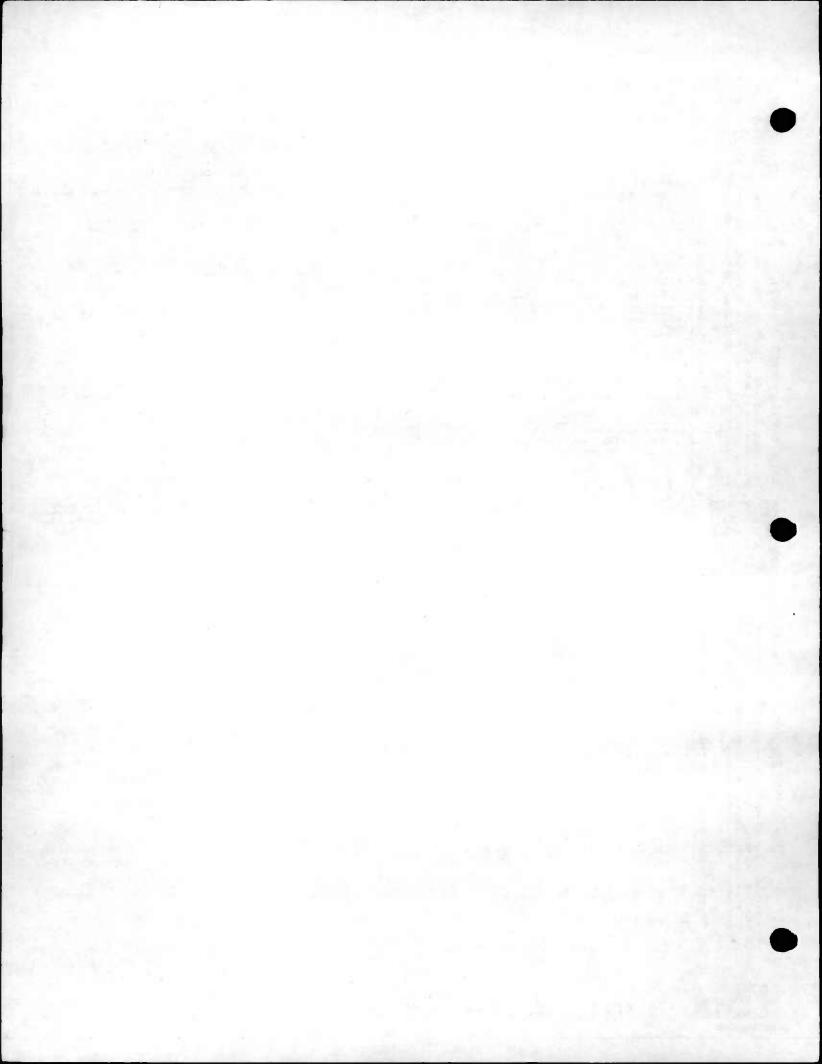
29c. Licanse number

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29d. Data signed (Month, Day, Year)

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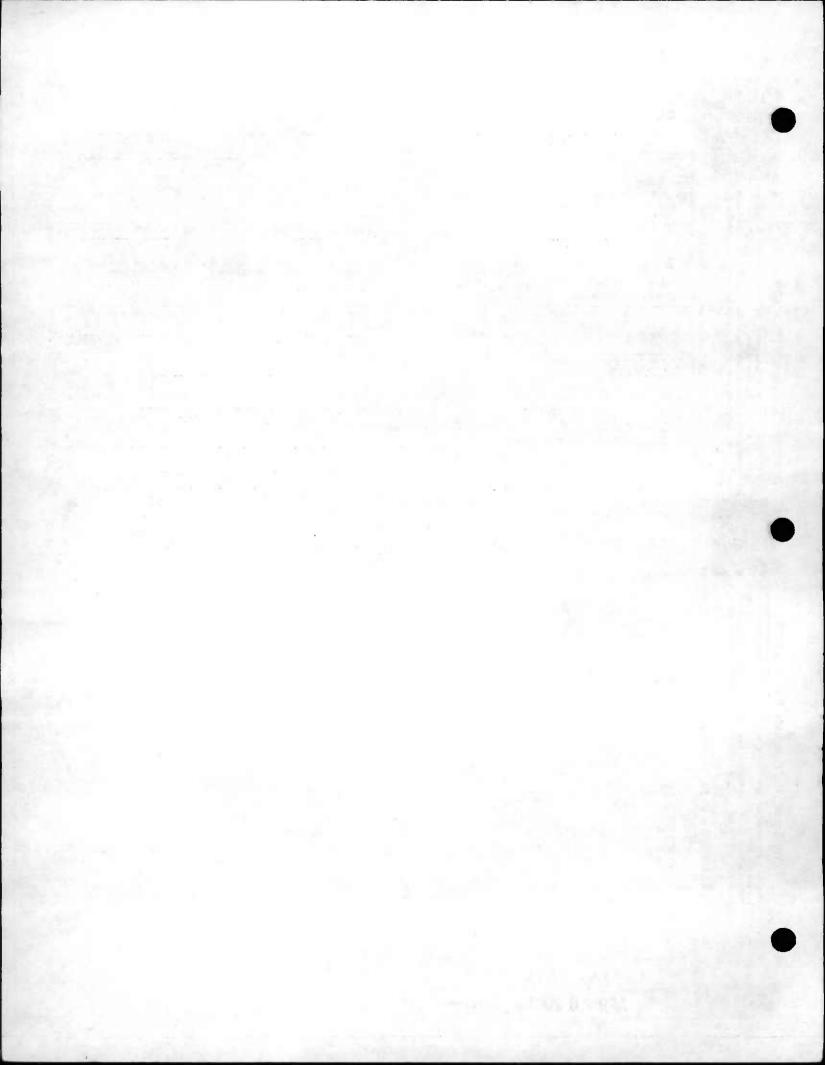
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/Medical Examiner	4e Fecility Neme (If not institution, g				4b. 0	City, Town,	or Location of De		ty of Death	0.05 pm
Examiner	Holy Cross Hospi	tal			Si	lver	Spring	Mont	gomery	7
Funeral			Age (In yrs. last birti	nday) If Under 1	rear If	Under 24 I	Hrs 9 Date of	Dieth	9	
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vith tha Ma t or 28a-f s be notified	Maryland Montgom	ery	Wheato	10f. Zip C	ndo.			10g. Citizen o	f Minet Cour	100
23a or	11501 Orebaugh A	venue		20902	, de			USA	T TTIME COUNT	ury r
permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercites must be notified at once.  To Be Completed by Funeral Director		12. Wes Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Deter	s? MNo	13. Wes Deceder If Yes, specify 1 ☐ Yes 2 €		nic Origin? Aexican, Pi pecify:	(Specify Yes or uerto Rican, etc.)		ace · Americ ack, White, ify: Whit	etc.
ed within 72 hours a ygiane. Nor than "natural", o nt, the Medical Exa Completed by	15. Decedent's (Specify only highest g	rede completed)		Decedent's Usuel ( Give kind of work of life. DO NOT use	occupation lone during retired)	n ng most of	working	16b. Kind of	Business/Inc	dustry
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2 st and is n	19e. Informent's Neme/Relationship			Mailing Address (5					n, Stete, Zip	Code)
end ealth n 27	Barbara B. Wurde	man/ Wife		501 Oreba		Ave,	Wheaton	1	902	
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orta	21. Signature of Foreign Service Lic	ensee		22. Name and			1		-F	-6,
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this ce al dire	1 ☐ Yes 2 🔀 No	Hospitel: 1 🔀 Inpa	tient 2 ER/Out	patient 3 DOA	Other:	4 Nursin	g Home 5 R	esidence 8 🗆 O	ther (Specif	y)
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30	Find	MA	unel	7 1	5996			April		
	30. Name and eddress of person who	111111111111111111111111111111111111111								
State	Linda Burrell, MD 31. Dete filed (Month, Day, Year)		dical Par	k Drive,	#210	, Si	lver Spi	ing, MD	20902	2
Registrar	APR 1 7 2	100 Dn	wa B	. Spar	61					



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of M	Maryland		artment rtificate			nd M		giene Reg. No.	146	35
Physic /Medi		Decedent's Neme (First, Middle, Last     Samu	•	ayton	Wo	ood				2. Deta of De Month April	Day	Yaar 2000 10	ima of Death: 35 PM
Exami Funeral Director		4a Facility Nama (If not institution, given FREDERICK MEMORI 5. Social Security Number 220 32 5175	AL HOSPI		ast birthday) Yrs.	If Under		FREDE If Under 24 Hours	RIC	8. Data of Bir	FRED	ERICK	State or Foreign
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15-0020 72 hours efter death with the Menyland "natural", or flems 23s or 28s-f show indical Examiner must be neutrised at	by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 ☐ Yas 22 If Yas, Giva Year or Date:	s? gNo		Was Decedent Yes, special	ify Cuba	spanic Origi n, Mexican, Specify:	in? (Spe Puarto F	cify Yas or No Rican, atc.)	Bla	ce - American Ind ck, White, etc. y: WHITE	dien,
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Baltimore, Maryland 212:  Jemii. Pages 1 end 2 should be filed within  Department of Health end Mantal Hygiene.  Important: If item 27 is marked other than  my loilury or, other traumatic event, that Mantal  page.	To Be	17. Fether's Nama (First, Middle, Last) RAYMOND WOOD  19a. Informant's Name/Reletionship (1)	Type, Print)		19b. Mailir	ng Address	(Street	LUL	_A 1	MAE FO	, Maiden Suman DRSTER er, City or Town	ne) , Stete, Zip Code	)
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Baltimore, N permit. Pages 1 end Department of Health Important: If item 27 any Injury or other u once.		4 Donation 5 Other (Specify 21. Signature of Funaral Sarvice Licen  Mu H	)		/ 1	Nama and	Addras	S of Fecility BARBE	ER F	/22/00 UNERAL	HOME	NSVILLE,	MD.
Physician		23a. Part1. Enter the disease, or compands, or heart failura. List only	olications that cause on aach	ed the death.			of rhyin	g, such as c	ardiac o	r respiretory a		Appr Intan Onsa	oximata val Between at and Daath
/ /Medical Examiner	ner	Immediate Causa (Final diseasa or condition rasulting in death)	a Col	Due to (or	es a consec	juence of):	lu	9,	bre	tore.	ree )	lo i	19
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- 5 m	ation: To	1 Yas 2 No  27. Mennar of Death  12 Natural 5 Pending 2 Accident invastigation	28a. Date of in (Month, I		R/Outpatier 28b. Time of Injury		Bc. Injun Wor	4 LI NUR	2		dence 6 Oth		
Division Mal or Attending urs after deeth. rel Director: After	Certification:	3 Suicide 6 Could not be determined	building,	atc."(Specify)		S. III C. III C.				City or To	wn, State)	ber or Rural Rou	te Number,
Division o  To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physics 2 Medical Example 19 Certifies 29b. Signatura and titla of certifies		of axaminetic		vestigation,	in my o				date and place,		
10		30. Nama and addrass of person who	Jew completed causa o	MD f death (Item	23a) (Type.	Print)	D	16675			4/	19/00	
		WAYNE /	Hachle	m,		NSU	(CK	y M	0	21	716		

State Registrar Hura G. Sparks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Month **Physician** April 2000 2:00am William R. Winterbourne /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Aug. 8, 192 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 6. Sex 1⊠ M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 79 1920 Director 118-09-2450 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or ferms 23s or 28s-f show traumatic event, the Medical Extension must be notified at 1 Yes ZENo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 20853 United States 4905 Flower Valley Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? X⊠ Yes 2 □ No. 1943— If Yes, Give Year or Dates: 1967 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Heelih and Martel Hygiene. Important: If Item 27 Is marked other than "natural", or iten any linjury or other traumatic event, the Madical Experimentials. 1 Never Married 21X Married 1 ☐ Yes A No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) U.S. Government Military 17. Father's Name /First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Doolittle 2 William Winterbourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4905 Flower Valley Drive Rockville, MD 20853 Rita Winterbourne/Wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ZXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4/14/00 Brentwood, MD Lincoln Crematory Ft. 22. Name end Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1725 11800 New Hampshire Ave. Silver Spring, MD 20904 the 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert leilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Hypostatic Pneumonia 24 Hrs. Examiner Due to (or as a consequence of): Examiner 18 Months Metastasis Axillae + Lungs physician end s the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Carcinoma, Squamous Cell, Skin 18 Months Physician/Medical Due to (or as a consequence of): **USB BS** lor use es 23b. Did tobacco use contributa to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably Wunknown signed by d be detect þ been sig 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? Hes page 2 1□ Yes XINo 1 ☐ Yes 2 ☐ No certificate director, 25. Was case relerred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes X2 No Medical Certification: To XX Inpatient 2 ER/Outpatient 3 DOA this After this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Dev Year) 28c. Injury et Work? 5 Pending investigation 1XX Netural To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director; Affe completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide

certificate be executed P.O. Box 68760. Records, Division of Vital Attending Physician:

Saltimore, Maryland 21215-0020

State Registrar

20

29a. Certifier

(Check only one)

nd title of certifie

29b. Signalure at

Donald R. Lewis, MD 31. Date liled (Month, Dey, Year)
APR 17 32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

end ma

4000 Olney-Laytonsville Road Olney, MD 20832

**DHMH 16 Rev 6/95** 

XX Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated.

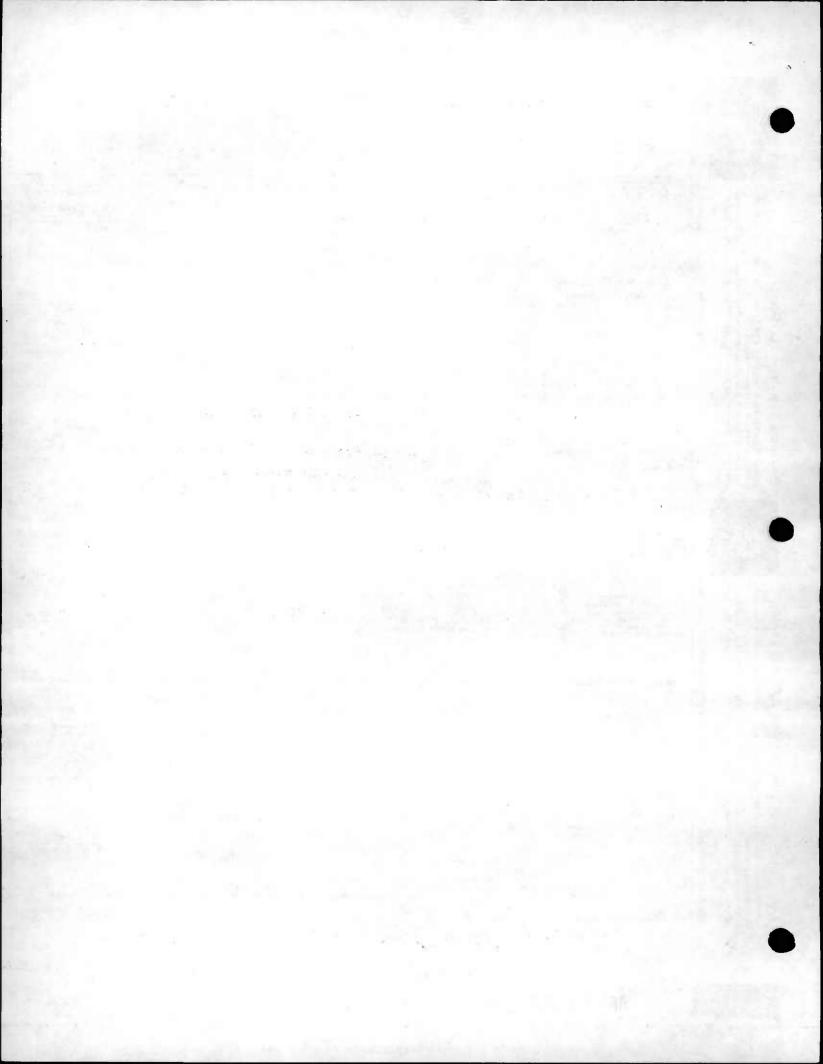
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

D06406

29c. License number

29d. Date signed (Month, Dey, Year)

April 7, 2000



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #2,4/27/2000, BMW, Montg. Co. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 Day ABNER R. WILLNER APRIL <del>13</del>, 2000 12:00AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death HEBREW HOME MONTGOMERY ROCKVILLE If Under 24 Hrs. Hours | Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) Months Days XX M 2 F 082-12-8454 82 APRIL 9,1918 NEW\_YORK Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2□No MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6121 MONTROSE ROAD 20852 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 104.1 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, XX Yes 2 No 1941 If Yes, Give Yeer or Dates: 1944 Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes → No Specify: Specify: WHITE ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ **ENGINEER** NAVAL DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) DAVID R. WILLNER NETTIE WOLFE 19e. fnformant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) NORMAN WILLNER SON 309 MARVIN RD. SILVER SPRING MD. 20907 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) CEDAR PARK CEMETERY APRIL 17,2000 PARAMUS N.J. 21. Signature of Fyneral 22. Name and Address of Facility Service License DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PK. ROCKVILLE MD. 20852 23a. Pert1. Enter the discose, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) COMA 2 MONTHS Due to (or as a consequenca of): SUB- DURAL HEMATOMA WEEKS Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): HYPERTENSION that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

ettending physicien end for use as the bunal-transit

signed by t

certificate

al or Attending Physician: T s aftar deeth. il Director: Atter this certificat od in by the funerel director, p

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Completed

Be

P

Certification:

Medical

Box 68760.

P.O.

Records.

Division of Vital

The law requires that the deeth certificate be

permit. Peges 1 and 2 should be filed w
Department of Health and Mentel Hygier
Important: It flem 27 is marked other th
any Injury or other traumatic event, inonce.

**Physician** 

Examiner

Director

Funeral

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**Funeral** 

Director

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Hygiene. other then "natural", or items 23s or 7 vent, the Medical Examiner must be r

the Marylend

21215-0020

Baltimore, Maryland

filed

Physician/Medical Examiner

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

MELLITUS

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 TYes 2 No

25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28c. Injury ef Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Deeft 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1& Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month; Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IPSON

MONTROSE RD ROCKVILLE20852

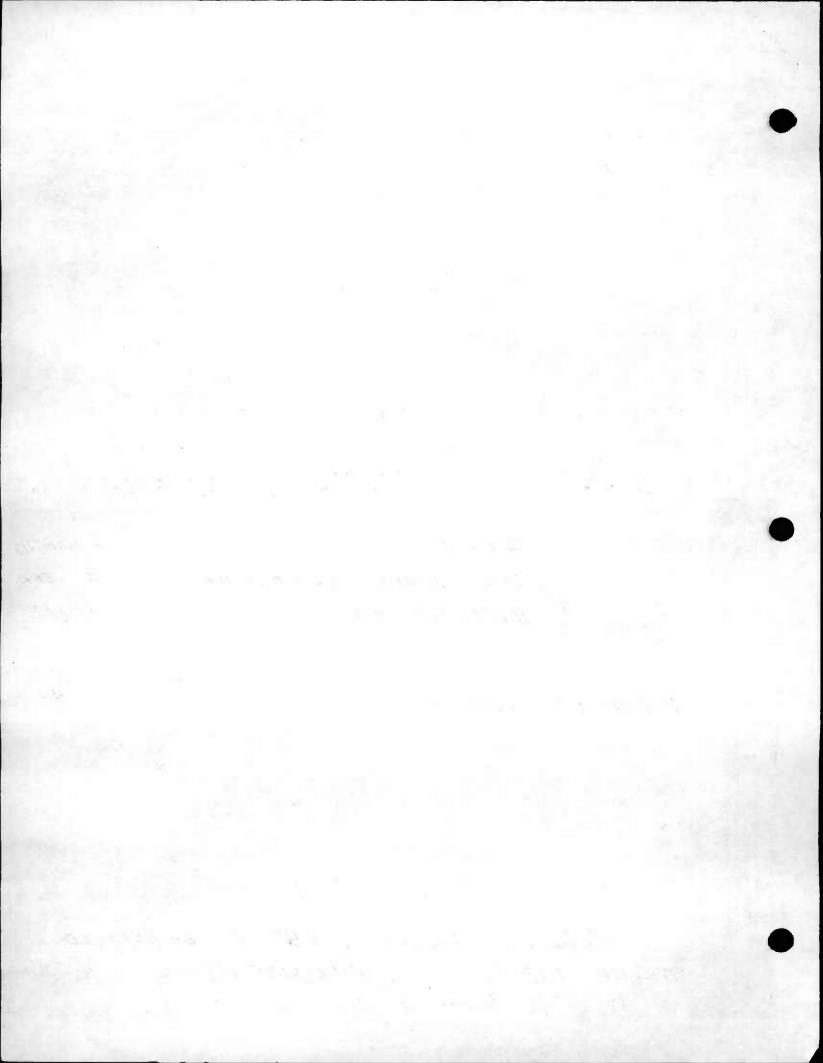
State Registrar

20

31. Date filed (Month, Day, Year) 2000 **APR 18** 

STEVEN

32. Registrar's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AS Month Year 1734 HILLEY DOUGHT WILLIAMS 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MONTEOMOSY silven servic 1615 TI YOW Drive If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Hours Months Days 490-34-1341 1 M 35F 65 Yrs. JUNE 21,1934 ILLINOIS Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√5No MARYLAND MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1615 TILTON DRIVE 20902 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 TVNo If Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Biack, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) PHILLIP BOHI ETHEL HAINES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOELLE WILLIAMS (DAUGHTER) 1615 TILTON DRIVE., SILVER, MARYLAND 20902 20b. Place of Disposition (Name of cametery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) APRIL CHESAPEAKE CREMATORY INC BELTSVILLE, MD 19, 2000 21. Signature of Funeral Servica Licenses 22. Name end Address of Facility BAPP FUNERAL AND CREMATION SERVICES 933 GIST AVE., SILVER SPRING, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Intervel Between Onset and Death APTERIOSCEPTOTE OMOJOURSCULL ON BOY Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of) 23b. Did tobacco usa contribute to the ceuee of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 DINO 1 Yes 2 No 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

ettending physician end for use as the burial-transit The law requires that the death certificete be executed P.O. Box 68760, been signed by the should be datached Division of Vital Records,

**Physician** 

/Medical

Examiner

Examiner Physician/Medical þ Completed Aftar this certificate has funeral director, pege 2 To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica complataly filled in by the funeral director, to Be 0 Certification:

**Physician** 

· /Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

death with the Marylend

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mantai Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Exament must be notified at

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? Yes 2□ No 27. Manner of Death

Natural

2□ Accident

4 Homicide

3 Suicide

29a. Certifier

5 Pending

Investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of Placa of injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated.

Con the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Sign and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moderne Pike, Rockville, NO 20852 CARL I. MEGOLI, MO 11/25

31. Date filed (Month, Dey, Year) **APR 19** 2000

32. Registrar's Signature

State Registrar

Medical





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #7,10a,4/20/2000, BMW, Montg.Co. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 10:24Am D. Henry White WILL 2000 /Medical 4a. Facility Name (if not institution, give street and numbar) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner OF PG Count Hyattsville HUQ++SUI and Ile If Under 1 Year 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 148 M 2 ☐ F 219-16-2100 Usual Residanca of Dacedent 74 Yrs. Director MD 10a. State DC 10b. County 10c. City, Town or Location 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified as once. 10d. Inside City Limits Washington Jior. Zip Code Director 12 Yes 2 No 10g. Citizen of What Country? 37th 20019 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2 ☐ No If Yas, Give Year or Dates: 1 ☐ Nevar Married 2 ☐ Married 21215-0020 1 Yes 2€ No Specify. Specify: BLACK 3 ₩idowed 4 Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamentary/Sacondary (0-12) Collaga (1-4or 5+) Self-Employed 900 Painter Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be Shorter Richard White ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) Deborah White Mulean- Daughter Bloom Rd. (MILL) SILVER SPRING, MD 20910 1220 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/20/00 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Netional 22. Name and Addrass of Facility 21. Signatura of Funeral Service Licensee MORTICIANS, INC. R. N. HORTON 12 Huston STREET, NW, DC 20011 KENNEDY 23a. Part 1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final diseasa or condition resulting in death) /Medical CARCINOMA, LUNG with Metastages Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death cartificate be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated avants rasulting In death) Last Due to (or as a consequance of): Box 68760, Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown Records, ģ Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: To Be 25. Was case referred to madical examiner? 28. Place of Daath (Check only one) Other: 4 virsing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Death 28c. Injury at Work? Certification: 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 5 Panding Investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft complately filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be datermined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person ORE MD 4008 Queensbury ld Hyattwille MD 20181

32. Registrar's Signatura

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month

DC . Set Markey

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth WHITAKER, JV. **Physician** GARFIELD 7.10 Pm 04-15-2000. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Laurel Regional Hospital Prince Georges Laurel Birth Day, Year) 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Deys Hours 63 Yrs 244-48-6853 Director Usual Residence of Decedent with the Marylend 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location "netural", or items 23a or 28a-f show edical Examinar must be notified at 1X Yes 2 No Director Prince Georges Adelphi Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20783 1801 Jasmine Terrace #202 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give Yeer or Detes: 1965 Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Americen Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health end Mantel Hygiena. Important: If Item 27 Is marked other than "netural", or item any injury or other treumatic event, the Medical Experiment once. 1 Never Married 2 Married Black 1 Yes 2 No  $\mathcal{U}$ Baltimore, Maryland 21215-0020 Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 4<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) Saleman Retail Clothing 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Sumame) Be Retha Silver Garfield Whitaker, Sr. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Wife 1801 Jasmine Terrace #202, Adelphi, MD Alice M. Whitaker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4/20/00 Washington, D.C. Mt. Olivet Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. rompson 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Anoxic Encephalopally Immediate Cause (Final disease or condition resulting in death) 7-10 Hrs /Medical Examiner Due to (or es e consequence of): 7-10 Amg Physician/Medical Examiner Respiralory arrest ettanding physician end for use es the bunel-transit The law requires thet the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) signad by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Carcinoma lung. Yes 2 No 3 Probably 4 Unknown à Herpertension 24b. Were eutopsy findings eveilable prior to completion of cause of death? been signature 24a. Wes en eutopsy performed? Completed s cartificate has I 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica complately filled in by the funeral director, I Be 25. Wes case referred to medical 26. Piece of Death (Check only one) examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Mapner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation **Y** □ Neturel 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifier (Check only one)

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. edical 29a, Certifier 29d. Date signed (Month, Day, Year) 4 / 15 / 2000. 29b. Signature)and title of certifier 29c. License number Ducudrup

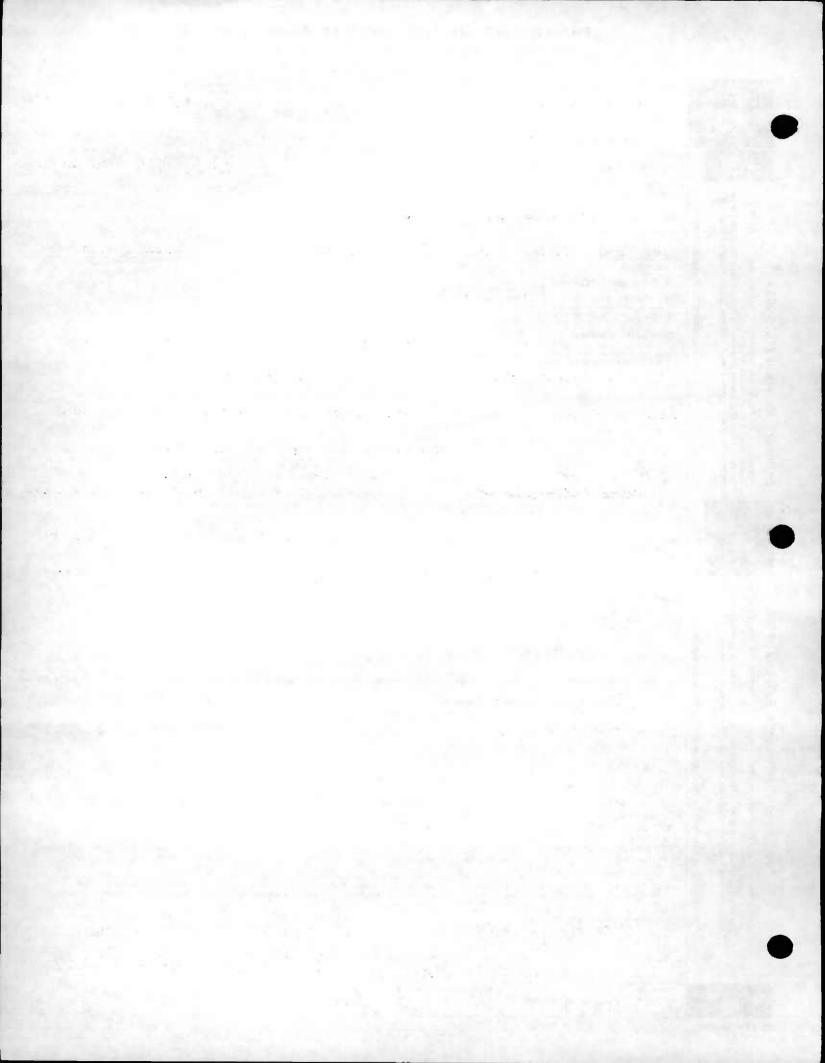
Registrar

31. Date filed (Month, Dey, Year) APR 1 9 2000

SPEUL MID

30. Nem and eddress of person who completed couse of deeth (Item 23e) (Type, Print) Readeus Gus MD 20710, 32. Registrer's Signature

042580



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

								of Death		rgiene		041
		ecedent's Nam	e (First, Middle,	Last)		site!			2. Date of De Month	eath Day	Year	3. Time of Death
nysician Medical	30 4000	YER WE	RTLIEB						APRIL	14, 200	0	9:38 AM
kaminei	4 - 2	Facility Name (/	f not institution,	give street and nu	imber)			4b. City, Town, or	Location of Deel	,		
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neral ector	57	79.48.56	584	5. Sex 1 ☑ M 2 ☐ F	7. Age (In y 8	Yrs. last birthd	Months	Year If Under 24 Hrs Days Hours Min	8. Date of Bi (Month, D) MAR 1	z, Year) 2, 1914	9. Birthpla Count	RUSSIA
		el Residence of State	Decedent 10b. County		100	City, Town or	Location			<del></del>	10	d. Inside City Limits
Meda			MONTGO	OMERY		•	SPRING				1.0	1 □ Yes 2 □ No
Director	10e.	Street and Nur	mber				10f. Zip (	Code		10g. Citizen of	Whet Count	ry?
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any injury or other traumatic a	21.	Signature of Fu	Service Li	censee		ING DA	22. Name and	Address of Fecility SAGEL FUNE	DAT DIDE	COTTONI 1		
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	23a	Pent Enter	he disease, or c	omplications that	caused the d	eath. Do not		of dying, such as cardia				Approximate
cian		shock, or hela	rt failure. List oi	nly one cause on	each line.			-				Intervel Between Onset end Death
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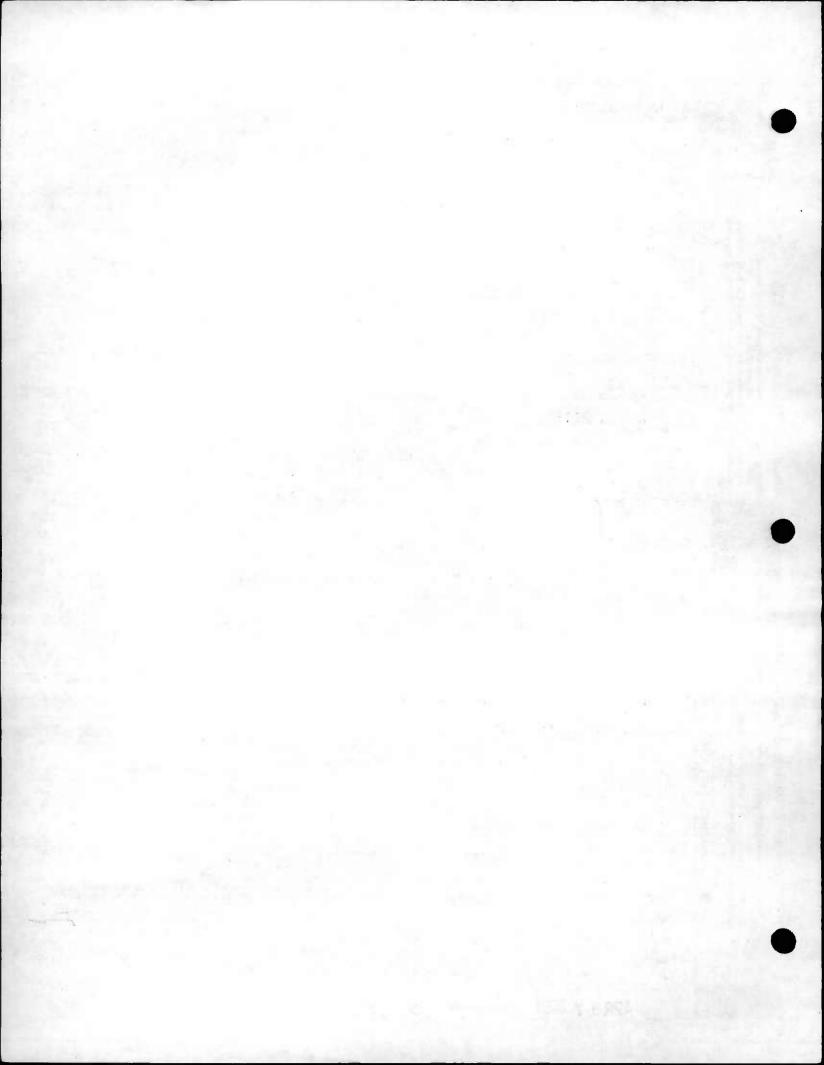
10313 Georgia 31. Date filed (Month, Day, Year) Registrar

30. Name and address of person who completed cause (0313 GROMIQ DVP

29c. License number

MD 25808

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

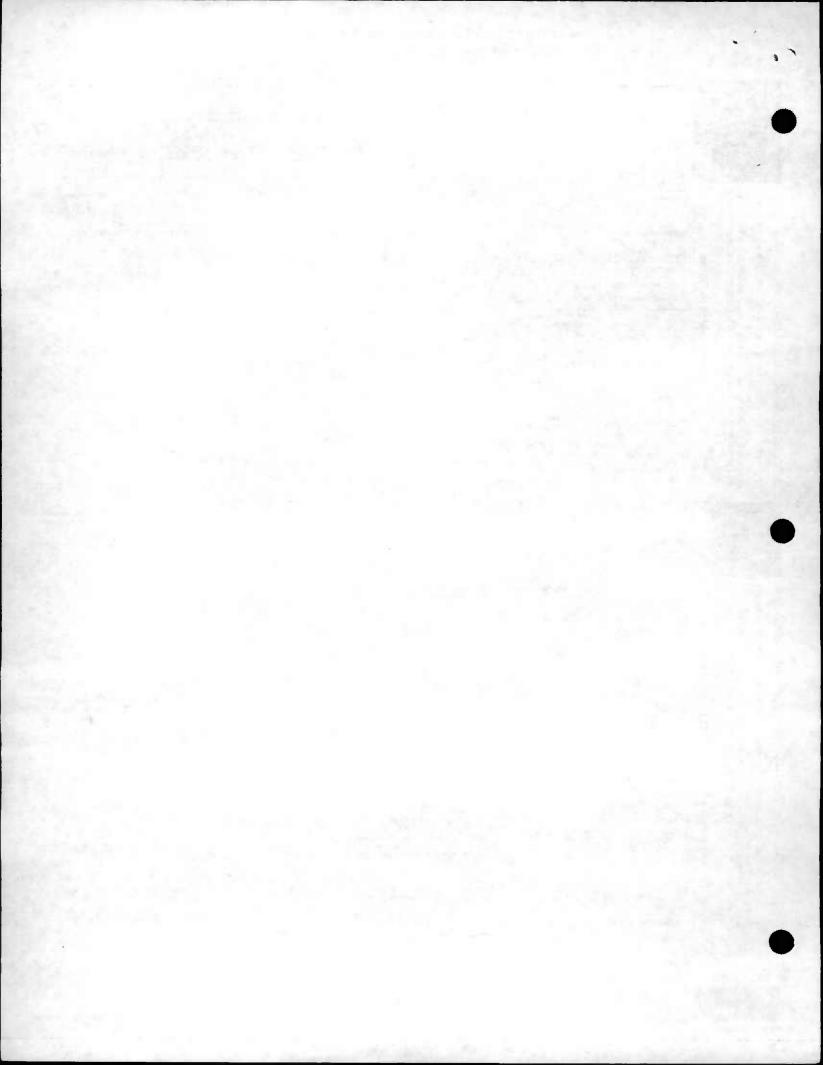
State of Maryland / Department of Health and Mental Hygiene Amend #5,4/21/2000, BMW, Montg. Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month **Physician** Paul Henry Wehrenberg April 15, 2000 12:45 am /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6028 Chatsworth Lane Bethesda Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex 1 M M 2 ☐ F 8. Date of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) **Funeral** 314-01-2958 Deys Months Director 81 July 12, 1918 Indiana Usuel Rasidence of Decedent with the Meryland 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits items 23s or 28s-f show permit, Pages 1 and 2 should be filed within 72 hours efter death with the Meryle popertment of Health and Mentel Hygiene. Importants if Hear 27 le merked other than "natural", or itema 23e or 28e-f ehow eny injury or other traumatic event, in a Medical Examine traus be notified as 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10e. Street end Number 10a. Citizen of Whet Country? Funeral 6028 Chatsworth Lane 20814 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Mentel Status 1 X Yes 2 No If Yas, Giva Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No WWII Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ Engineer Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Paul Carl Wehrenberg 2 Ella Buesching 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rurel Routa Number, City or Town, Stete, Zip Code) Emma J. Wehrenberg/ 6028 Chatsworth Lane Bethesda, Maryland 20814-2206 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State April 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium Inc. 18, 2000 Bethesda, Maryland 21. Signature of Fundial Service Licensee

22. Neme end Address of Fecility
Robert A. Fumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue

M00335Bethesda, Maryland 20814-3501

23a. Part. Enter the disease, or complications that caused that death. Do not antar tha mode of dying, such as cardiac or respiretory errest,
Approximate Approximete Interval Between Onset end Death **Physician** /Medical Immediata Causa (Finel Small Cell Lung Cancer with Metastasis diseasa or condition resulting in death) 8 Months Examiner Due to (or es e consequance of) Examiner physicien end the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t d be detach 3⊠ Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ Division of Vital Records. 24b. Were eutopsy findings evailable prior to complation of causa of deeth? 24a. Wes en autopsy performed? Completed 1 Tyes 2 No 1 ∏Yes 2 ∏ No certificate Physician: Be 25. Was case referred to medical 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 2 spital or Attending Physhours after death.
nerel Director; After this y filled in by the funerel di After this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel Injury 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours a 29a Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, deta and place, end dua to the ceusa(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end dua to tha cause(s) and mannar stated. Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signefure end title of cartified 15+ D33224 April 17, 2000 30. Neme end eddress of person who complated cause of deeth (Item 23e) (Type, Print) 50 West Edmonston Drive #303, Rockville, Maryland 20852 Ram S. Trehan, M.D. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State oaks Depera APR 19 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** noi House 04 /Medical 4b. Gity, Town, or Location of Death 4q. County of Dean...

Mymtgmen

Inne (State of 4a Fecility Neme (If not institution, give street and number) Examiner Kockville Muncaster Mil If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yes, last birthday) **Funeral** Days 1□ M 20 F Director 214-15-0455 Usual Residence of Decedent the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28s-f show eny Injury or other traumatic event, the Medical Environment is notified at one of the contract in 1 may no vi 1 ☐ Yes 2 No Director Rockville 10g. Citizen of Whet Country? 10e. Street end Numbe 10f. Zip Code 11923 Parklawn Drive, 204 Funeral 20852 China 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Mentet Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: À Specify: 3₺ Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Unknown Lei Unknown 19a. Intormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Man/Son 7744 Barnstable Place, Rockville, MD. 20855 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/22/00 | Silver Spring, MD. 22. Name and Address of Fecility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23e. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical . Small cell lung 2month Examiner Physician/Medical Examiner for use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Due to (or as a consequence of): ate hes been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were autopsy tindings available prior to completion of ceuse ot death? Be Completed 24a. Wes an autopsy performed' After this certificate hes 1 ☐ Yes 28100 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: director. 25. Wes case reterred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6-Tother (Specify) Hospic Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel tniury within 24 hours after deeth.

To the Funeral Director; Af
completaly filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifier edical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature No Okcertifie 00054378 3 Aylervoth 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Eugene P. Libre,

APR

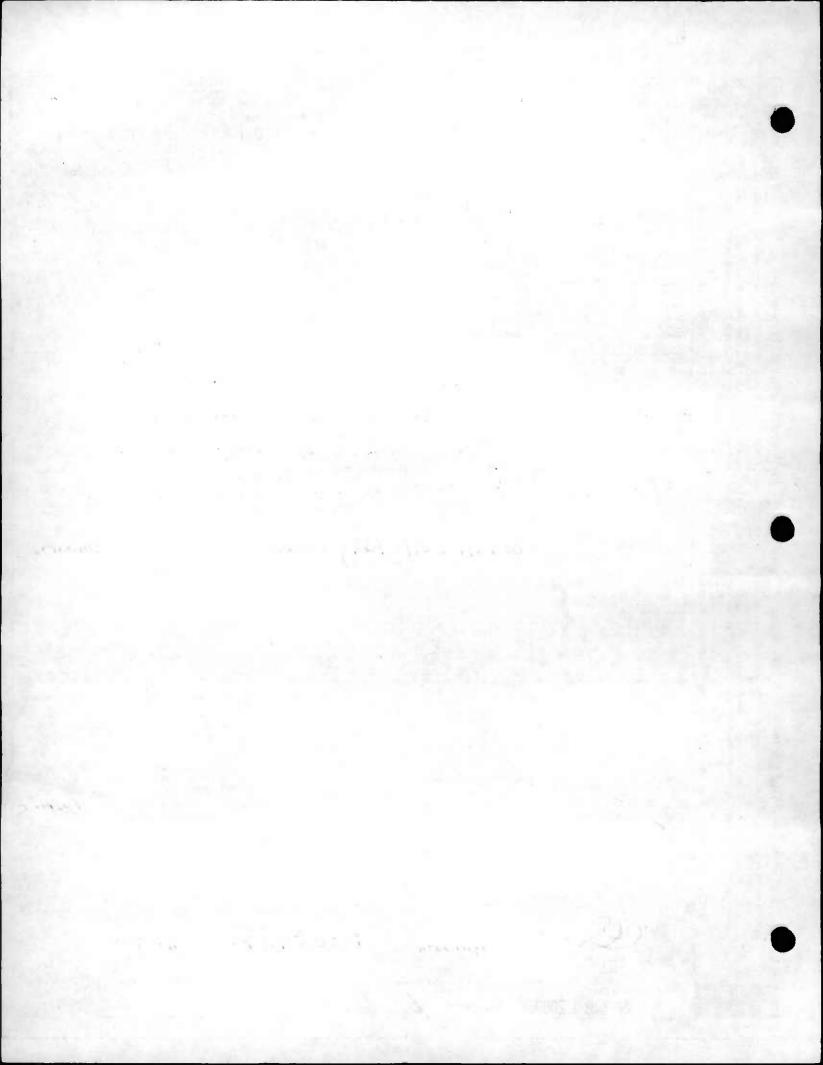
31. Date filed (Month, Day, Year)

M.D.

2 1 2000

32. Registrer's Signature

10400 Connecticut Avenue, # 606, Kensington, MD. 20895



## Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

					C	partment of F ertificate of	Death			Reg. No.		0 7 7
		1. Decedent's Name (First, Middle,	Last)		777				2. Date of De Month	ath Day	Year	3. Time of Deeti
Physiciar /Medica	_	Vivian Cohn	York							18, 2000		16:49
Examine		4a Fecility Neme (If not institution,	give street and nun	nber)			4b. City, To	wn, or Lo	cation of Deatl	4c. County	of Death	
		SHADY GROVE						KVIL			rgom	
Funeral			6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 80		Months   Davs		Min.	8. Dete of Bir (Month, De	y, Yeer)	9. Birthp	place <i>(State or Fore</i> ntry) Yo <b>rk</b>
Director		125-10-1014 Usual Residence of Decedent		80	,				Sept.	7,1919	New	IOIK
MOI W		10a. State 10b. County		10c. Ci	ty, Town or	Location					1	10d. Inside City Lin
The Date of the Da	형	Maryland Montgo	mery	Ro	ckvi1	1e						1 ☐ Yes 2 🔀
or 28	Director	10e. Street and Number	3,			10f. Zip Code				10g. Citizen of	What Cou	ntry?
		1515 Dunster Str	eet			20854				USA		
Net Fi	Funeral	11. Marital Status	12. Was Dece Armed For	rces?	I,S. 1:	<ol><li>Was Decedent of I If Yes, specify Cub</li></ol>	Hispanic Ori an, Mexican	gin? (Spe ı, Puerto l	ecify Yes or No Rican, etc.)		e - Ameri ck, White,	can Indian, etc.
or in	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	е		1 ☐ Yes 21 No	Specify:			Specify	/: TTle -	
natural', or	8	15. Decedent's	Year or Da	1165.	16a Dec	cedent's Usual Occu	nation			16b. Kind of B	Wh:	
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than	E	Elementary/Secondary (0-12)	College (1	-40r 5+)	Cas	shier				Bank		
T to 5	Bec	17. Father's Name (First, Middle, Li	ast)				18. Mothe	r's Name	(First, Middle	, Maiden Suman	ne)	
marked marked imatic e	0	Harry Cohn					Beat:	rice	Silber	rt		
and s m		19a. fnformant's Name/Relationshi	p (Type, Print)			ailing Address (Stree				-		
Item 27		Jeffery York/Son	n			04 Shakesp	eare 1	Dr.,	German			
5 5 50		20a. Method of Disposition 1★ Burial 2 □ Cremation 3	Removal from S		Place of Dis cemetery, c	sposition (Neme of cremetory or other pla	ace)	A	Date pril	20c. Location -	City or T	own, State
Department of H Important: If Ite any Injury or of DDCs.		4 ☐ Donation 5 ☐ Other (Spe		Ari	Lingto	on Nationa	al Cem	• 2	1,2000	Arlingt	on,	Virginia
aport ny Inj		21. Signature of Funeral Service Li	censee	1		22. Name and Addre Pearson H			m e			
TANDAL POLICE	- 1	Shock, of heart failure. List of	nly one cause on e	aused the dea ach line.	th. Do not o	enter the mode of dy	ing, such es	cardiac c	on St.	rrest,	CHUI	Approximate Interval Between
ysician Medical aminer		Immediate Cause (Finel disease or condition resulting in death)	nly one cause on e	tic Sh	ock	enter the mode of dyi	ing, such es	cardiac c	on St., or respiratory a	, FAILS	Citati	Approximate Interval Between
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Registrar

APR 21 2000 5 Server G. Aparle

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Yaar **Physician** Frances Jean 17 2000 April 11:15 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) **Funeral** Days 1 □ M 2K) F Yrs. 579-36-2340 70 Director Oct. 24, 1929 Maryland Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahow permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Depertment of Health and Mentel Hygiens. Important: if flem 27 is marked other than "natural", or itema 23s or 28s-f show any lighty or other treumatic event, the Madical Examiner must be notified an once. 1 ☐ Yas 2 ☑ No Director Maryland Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Metzerott Road 20783 **IISA** Funeral 11. Meritel Status 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White P 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Receptionist Insurance 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Charles Shipe Alice A. Gormer 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5904 Pontiac Street, Berwyn Heights, MD Cheryl Compton / Daughter 20740 20b. Place of Disposition (Name of cematary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 CCramation 3 Personal from State Fort Lincoln Crematory 4 Donation 5 Other (Special) 04/19/00 Brentwood, Maryland 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue 21. Signature of Funeral Service Co. 20904 Silver Spring, Maryland far tha disaase, or complications that caused tha daath. Do not entar tha moda of dyirig, such as cardiac or raspiratory arrast, rhaart failure. List only one causa on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** /Medical Immediete Ceuse (Finel disaasa or condition rasulting in death) Metastatic Carcinoma months Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiata causa. Enter Undarlying Ceusa (Diseesa or Injury that initieted events rasulting in death) Last Dua to (or as a consequenca of): P.O. Box 68760. Dua to (or es e consequance of) been signed by the should be detached Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Records, by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy parformed? complation of causa of death? ils certificate has I director, pege 2 1 Yas 2 No 1 Yas 2 No Division of Vital 8 25. Wes case rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this lunerel 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 5 Pending 1 Natural n 24 hours after deeth. 1 Tas 2 No investigetion 2 Accidant 6 Could not be datermined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 | Homicida Hospital 29a. Cartifier edical 1 Certifying Phyeician: To the best of my knowledga, deeth occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as steted. To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature end titla of certifier

State Registrar

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31. Data filed (Month, Day, Year) APR 2 0 2000

Rajeev Batra, M.D.

10801 Lockwood Drive, #325, Silver Spring, Maryland 32. Begistrar's Signeture

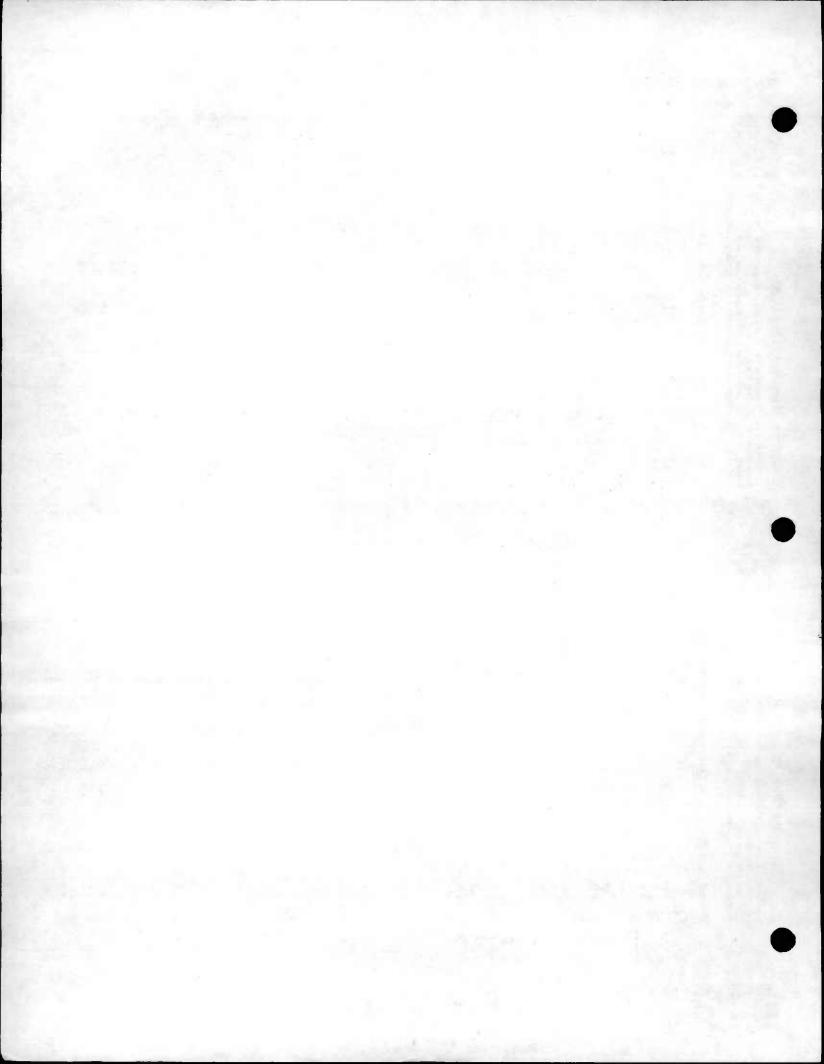
02

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

MD

D50678

2000



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

1 Decedents Non- /	Tires (Alabate 1			Cei	rtificate o	Death	nd Mental H	Reg. No.		646 3. Time of Death
1. Decedent's Name (First, Middle, Last)  Michael Shaler Archer						May 1	May 1, 2000 Year 7:08 PM			
4a Fecility Name (If not institution, give street and number) Stella Maris Hospice Care Center					4b. City, Town, or Location of Townson		an of Death 4c. County of Death Baltimore		e	
5. Social Security Num 219-62-729	3	ex 7 EAM 2□ F	Age (In yrs. 44	last birthday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of E (Month, I	Birth Pay, Year) 22,1955	Countr	ce (State or Fore
Usual Residence of De										
PA 10	b. County YO1	rk	10c. Cit	y, Town or Lo		ed Lion			100	d. Inside City Lim 1 ☐ Yes 2 🔯 I
10e. Street and Numbe	r				10f. Zip Code			10g. Citizen of What Country?		y?
314 PI	Corner	ner Ct. 17356			6	United States				
11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		Armed Ford 1 Tes 2 If Yes, Give	Armed Forces? If Yes, specify Cuba		ıban, Mexican,	Hispanic Origin? (Specity Yes or No- ban, Mexican, Puerto Rican, etc.)  Specify:		14. Raca - American Indian, Black, White, etc.  Specify: White		
	ucation de completed)		16a. Dece	dent's Usuai Occ kind of work dor	upation e during most	of working	16b. Kind of B	usiness/Indu	stry	
Elementary/Seconda		Coilege (1-	lor 5+)		kind of work dor DO NOT use reti				100	
10 Years  17. Father's Name (Fire	st Middle Leen		1911	Sales	Represe		's Name (First, Midd		ales	
Austin V		er, Sr.					Anita Mar			
19a. Informant's Name		-		19b. Mailir	ng Address (Stre		r or Rural Route Num			Code)
Mrs. Merry			fe)				er Ct. R			7356
20a. Method of Disposi				lace of Dispo	sition (Name of metory or other p	lace)	Date	20c. Location -	- City or Tow	m, State
P☐ Burial 2 ☐ C 4 ☐ Donation 5			are				5/4/2000	Roseda	ale, M	aryland
Immediate Cause (Fin disease or condition resulting in death)  Sequentially list condit if any, leeding to imme cause. Enter Underlyit Cause (Disease or Injuite Initiated events		a	Due to (c	fal or es a consec or as a consec		inon	19			
cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d										
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause g								obacco use contribute to the cause of dee Yes 2□ No 3□ Probably 4⊠ Unkn		
	e ju							as an autopsy normed?	avai	e autopsy finding lable prior to apletion of cause eath?
							10	☐ Yes 2 🖾 No	10	Yes 2□ No
25. Was case referred examiner?	to medical	Hospital:			1,		of Death (Check onl			11
1 ☐ Yes 2 ☑ No 27. Manner of Death				ER/Outpatier	II JU DOA		rsing Home 5 Re	esidenca 6 DiOth		Hospica
1 □Natural 5	Pending investigation			28b. Time o Injury	M 1	☐ Yes 2☐ N	No			
4 ☐ Homicide	determined						moute Number,			
			is of examina				d place, and due to the h occurred at the time			
29b. Signature and title	of certifier	and the second second		31.5		nse number		29d. Date signe		Pay, Year)
) Jain	1				Du	13725		5/3	lov	
30. Name and address  IARIQ M.  31. Date filed (Month, I	Attmo	012 201-	of death (Item	Back	Print) River	Neck	Road	Baltin	rue	MD212

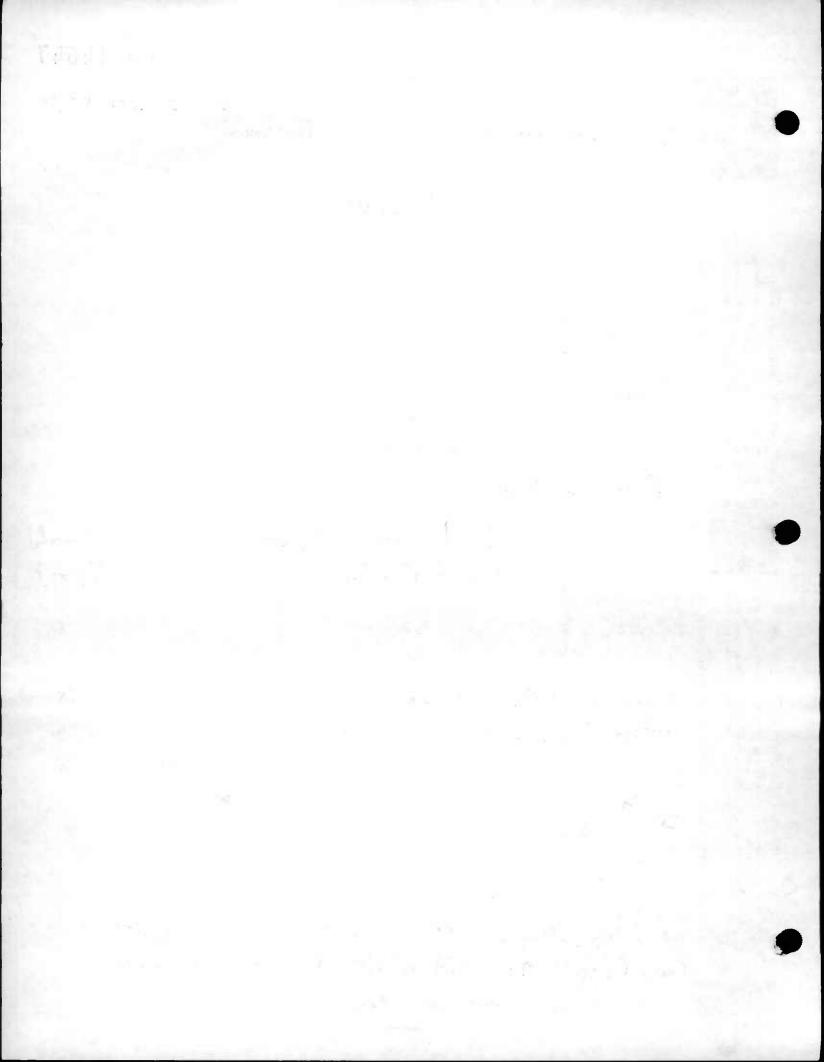
DHMH 16 Rev 6/95

Registrar

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			Certificate of		R	eg. No.	14047
Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Dete of Dee Month	th Dey Yee	3. Time of Deeth
/Med	ical	Pedro Alfonso	1	di Oh Tarahari	5	2 308	
Exami	ner	4a. Fecility Name (If not institution, give street end number)  324 S. Macon St		4b. City Town or Lo	TOP	4c. County of De	eth
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. 1 ☐ M 2 ☐ F 8. Sex 1 ☐ M 2	85 Yrs. If Under 1 Year Months Deys		8. Date of Birth (Month, Dey OCT 31	, 1914 Cu	irthplace (State or Foreign Country) ba
ye =			y, Fown or Location				10d. Inside City Limits
Man,	ţō	MD N/A	Baldmore				1 LYes 2 □ No
th the	ie	10e. Street end Number	10f. Zip Code		1	log. Citizen of Whet	Country?
th wil	<u>a</u>	324 S. Macon Street	21224			Cuban Ref	ugee
Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mentel thygiene. Important: if tem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Expirition mast be notified at any place.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 (\$20) vorced  12. Wes Decedent Ever in U. Armed Forces? 1   Yes (\$20) vorced 12. Wes Decedent Ever in U. Armed Forces? 14. Wes Decedent Ever in U. Armed Forces? 15. Wes Decedent Ever in U. Armed Forces? 16. Yes Give Year or Pates:	,S. 13. Was Decedent of I It Yes, specify Cub 1 ☐ Yes 2 ☐ No		ecify Yes or No- Rican, etc.)		
First Pour	b d	3 ☐ Wildowed 4 ☑ Wildowed Year or Dates:  15. Decedent's Education	16a. Decedent's Usuel Occup	Cuban		Specify: White	*
21215-0020 d within 72 hours af giene. In then "netural", or the Medical Expiri	To Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+	(Give kind of work done life. DO NOT use retire	pation during most of work id)	ing	16b. Kind of Busines Self Empy	
E Hyg	O	17. Fether's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, i	Meiden Sumeme)	
/lar	0 8	Manuel Alfonso		Margeur	ita Col	.az	
Maryland of 2 should be file th end Mentel Hy t7 is marked othe treumatic event		19e. intorment's Name/Relationship (Type, Print)	19b. Mailing Address (Street	t end Number or Run	el Route Number	, City or Town, Stete	Zip Code)
end 2		Pedro Alfonso, Jr. / Son	8229 Bonair		imore, N	MD 21234.	
Baltimore, bemit. Peges 1 er Depertment of Hea moortant: If Item's iny Injury or other ance.		I L Dunai 2 L Cientettori 3 Linentoval tioni State	Place of Disposition (Name of emetery, crematory or other pla ETRO CRGW	CO)	Date May 8 2000	20c. Location - City o	or Town, State
permit. Depending	p. 4	21. Signature of Funeral Service Licensee				Home, P. <i>I</i> et Baltin	A. nore, MD
F.C. DOX 00/00, requires that the death certificate be executed with the effect of the estending physician end include be detected for use es the buriel-transit.	Physician/Medical Examiner	if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury c.	r es e consequence ot):	Juses -			16 monts
Jeath Jeath difor a	clai	Part II. Other significent conditions contributing to death but not resi	deline in the conduct to a second	and in Daniel	OOD Did a		A. A. M
dS, F.C. DOX lires that the death cer signed by the ettendir id be deteched for use	by Phys	0 2	cause gr	ven in Pert I.		es 2 No 3	te to the cause of death? Probably 42 Unknown
2 20 00	Completed t	Atimal fils. lation	1		24a. Was a perform	n autopsy med?	. Were eutopsy tindings available prior to completion of cause of deeth?
The law interpretation that the page 2 st	S				1 🗆 Y	es ZX No	1 ☐ Yes 🌠 No
VITAL slcien: The certificete	Be	25. Wes case reterred to medical exeminer?		26. Piace of Deat	h (Check only on	ie)	
a fi si s	ation: To	1 Ves 2 No Hospitel: 1 Inpatient 2   27 Manner of Death 1 Naturel 5 Pending Investigation   Pending In	28b. Time of Injury Wo			ence 6 Other (Sp ow injury occurred	ecify)
To the Hospital or Attending F within 24 hours effer death. To tha Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At he building, etc. (Specify)	ome, farm, street, factory, office		28f. Location (Si City or Town	treet end Number or i n, Stete)	Rure! Route Number,
Hospi 24 hour Funer.	Medical	29a. Certifler (Check only one)   2   Medicat Examiner: On the basis of examiner on the basis of examiner and mander stated	wledge, death occurred et the ti tion end/or investigation, in my o	me, date end place, opinion, deeth occurr	end due to the cred et the time, d	euse(s) end menner ate and place, end d	es steted. ue to the ceuse(s)
To the within 2 To the comple	Mec	29b. Signaturi and title of castilier	29c. Licens	se number		9d. Date signed (Mo.	
B		30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	Baldin	re, M.	D 21224	-
Sta Regist		31. Date filed (Month, Dey, Year) 32. Registrer's Signa					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	st)		a de la constante de la consta		2. Date of De Month	rgiene () ( Reg. No. Path Day		Time of Deat
4a Facility Name (If not institution, giv	Larry	Bell		4b. City, Town, or I	MAY ocation of Deel	02,20 th 4c. County		:52P.N
SINAI HOSPITAL	e street and number)					40. Oddiny	OI Death	
5. Social Security Number 6. S		s. lest birthdey)	If Under 1 Year Months Days			rth	9. Birthplace Country)	(Stete or For
213-40-8303	XM 2□ F 52	Yrs.	MONINS Days	Hours Will.	8. Date of Bi (Month, Di 8-15	-1947	Country	V.C.
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location							10d. I	nside City Li
Md N/A		ltimor						YYes 2
10e. Street and Number	00	LI CIMOI	10f. Zip Code			10g. Citizen of V	What Country?	
2811 Silverhills Avenue 21207						US	А	
11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Decedent of	Hispanic Origin? (S	pecify Yes or No		e - American Ir	ndian,
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 Yes 2\(\)(No If Yes, Give Year or Dates:	de a	1 □ Yes 2/□XNo		11.5611, 010.7	Specify		<
15. Decedent's Ed (Specify only highest gre		16a. Dece	dent's Usuel Occu	pation	kina	16b. Kind of Bu	usiness/Industr	у
Elementery/Secondary (0-12)	College (1-4or 5+)			during most of wor	niy	Kennec	ott Cop	per
10th grade	N/A	tra	in operat		on (First Add.)	Plant		
17. Fether's Neme (First, Middle, Last)				18. Mother's Nan		, Maiden Sumen	10)	
Cleo Bell  19a. Informant's Name/Relationship (	Type Print)	19h Meili	ing Address (Stree	Victoria tend Number or Ru		per City or Town	State 7in Con	le)
Latonya Bell- Dau	**			ourt Bal		21244	01010, 210 000	,
20a. Method of Disposition	3	Place of Disp	osition (Name of		Date	20c. Location -	City or Town,	State
1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			metory or other pla Memorial		5-8-00	Arbutus	. Md	
21. Signature of Funeral Service Licen			2. Name and Addr	ess of Facility			,	
+ SUGARAN	ADCO 2		March F	/H West abash Ave	nuo Pa	ltimono	Md 2	1215
23g Part I. Enter the disease, or com	plications that caused the dea	ath. Do not en					Apr	roximete
shock, or heart failure. List only	one cause on each line.						Ons	rval Betwee set and Dea
Immediate Cause (Final disease or condition	PULMONAR	Y THRO	MBO_EMBOL	ISM				
resulting in death)  Due to (or es a consequence of):								
b								
Sequentially list conditions, if any, leading to immediate								
ceuse. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):								
resulting in death) Last	Due to	or as a consec	quence or).					
d								
Pert II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of de
CARDIAC HYPERTROPHY					1 Yes 2 No 3 Probably		450ini	
							045 44	uton- t- t
						s en eutopsy ormed?	comple	le prior to tion of ceus
					pen		of deat	h?
			AWA			<i>i.</i> –	1	
Or Western					15	Kes 2□No	Mye	s 2 No
25. Wes cese referred to medicel examiner?	Hospitel:	150/0	at 20 pp. 0	26. Place of Dec	1/5	one)		s 2 No
examiner?  TAYes 2 No  27. Menner of Death	28a. Date of Injury	ER/Outpatie	III JU DON	her: 4 Nursing H	1/5 ath (Check only ome 5 □ Res		ner (Specify)	s 2 No
examiner?	28a. Date of Injury (Month, Dey Year)	A	of 28c. Inju	her: 4 Nursing H	1/5 ath (Check only ome 5 □ Res	one) idence 6 □Oth	ner (Specify)	s 2 No
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examiner?  To Yes 2 No  27. Menner of Death  1 Naturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier  2 No  5 Pending investigation of bettermined	28a. Date of Injury (Month, Dey Year)  28e. Place of Injury - At	28b. Time of Injury home, farm, st	of 28c. Injunction of 10 control of 10 contr	ther:    A   Nursing H   Nursi	ath (Check only one 5   Res 28d. Describe 28f. Location City or To	one) sidence 6 Oth how injury occur (Street end Numb wm, Stete) e cause(s) and mi	ner (Specify) rred ber or Rural Ro	ute Number
examiner?  72 Menner of Death 1 Naturel 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined  29a. Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month, Dey Year)  28e. Place of Injury - At building, etc. (Spectarille)  yelclan: To the best of my kniner: On the best of exemin	28b. Time of Injury home, farm, st	of 28c. Inju.  M 1 1  reet, factory, office  th occurred at the to the street of the s	ther:    A   Nursing H   Nursi	ath (Check only one 5   Res 28d. Describe 28f. Location City or To	one) sidence 6 Oth how injury occur (Street end Numb wm, Stete) e cause(s) and mi	her (Specify) red ber or Rural Ro anner as statedend due to the	ute Number 1. cause(s)
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examiner?  77 Menner of Death  1 Naturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  Control of the certifier  Co	28a. Date of Injury (Month, Dey Year)  28e. Place of Injury - At building, etc. (Special Property of the Desis of exeminand manner stated.	28b. Time of Injury home, farm, starm, starm	of 28c. Inju Wc M 1 [28c. Inju M 1 [28c	ther: 4 Nursing Harry et oxt? Yes 2 No ime, date and place opinion, death occuse number	ath (Check only one 5   Res 28d. Describe 28f. Location City or To	one)  idence 6 Oth how injury occur (Street end Numb own, Stete)  e cause(s) and mi , date and place,	ner (Specify) rred ber or Rural Ro anner as stated and due to the	ute Numbei i. cause(s)
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Daath Month Year Burnette Vosephine 5 1901 00 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not Institution, give street and number) Hospital Prince George's Regional Laurel aurel If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Days 1 ☐ M 2 🖫 F 579-34-6761 Yrs Nov. 13, 1928 Wash., D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 10a. Stata 1 ☐ Yes 2 ☐ No Md. Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 6513 Park Hall Drive 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify White 3 ₩ Widowed 4 Divorced 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) Grade 7 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dominic Borrelli Josephine Culchi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) r 6513 Park Hall Drive Laurel,
20b. Place of Disposition (Name of cemetery, crematory or other place)

May 9. Christine Maddox / daughter Maryland 20707 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) May 9, Md. Veterans Cemetery Cheltenham, Maryland 2000 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee \_ / MOO770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 months Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in deeth) Lest Dua to (or as a consequence of): Due to (or es a consaguence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy 2 No 1 ☐ Yas 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 ☐ Accident 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Spacity) 4 Homicide

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: efter deet Director: Hospital

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be ပ

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23s or 28s-1 show other trsumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours efter to Depertment of Heelth and Mertel Hygiene. Important: If Item 27 is marked other than "natural", or Ne any Injury or other traumatic event, the Medical Evanties any Injury or other traumatic event, the Medical Evanties.

**Physician** 

/Medical

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Certification:

Medical

altimore, Maryland 21215-0020

deeth with the Marylend

24 hours e To the Hosp within 24 ho To the Fune

Registrar

TAKY 31. Date filed (Month, Day, Year) MAY 0 8 2000

29a. Certifier

(Check only one)

29b. Signeture and title at the

MOURTZANAKIS 32. Registrar's Signature

dun

allas

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

3450 Fort Meade Rd

15 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and mannar as statad.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. Licansa number

D08307

29d. Date signed (Month, Day, Year)

Swife 109, Laurel

Marian Maria Caranta C

8.17.00

#### Please Type or Print in Biack indeiibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMENDED ITEMS #8,9 PER FH G783 5/10/2000 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUSEPHINE **Physician** 3,20009:00 AM 5. BIALEK /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner STREET GLEN BURNIE ANNE ARUNTEL 2 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 213 033532 Months 1 □ M 2 7 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Directo MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 C STREET, S.W. 21061 U.S.A. era 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Fun 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medical ORGE. Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS TAILORING 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be 2 (UNKNOWN) KRYMINSKI HELEN WILZACK 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOSEPH RICHARD BIALEK 212 C STREET, S.W., GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5/8/2000 H Burial 2 ☐ Cremation 3 ☐ Removel from State BALTIMORE NATIONAL CEMETERY BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) DEHYDRATION Examiner Due to (or as a consequence of) Examiner ANOREXIA physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DEMENTIA

Due to (or as a consequence of): Physician/Medicai CEREBRO VASCULAL INSUFFICIENCY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CORUNARY ARTERY DISEASE 1 Yss 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to PRIMARY HYPOTHYROIDISM DEPRESSION completion of ceuse of death? OSTEOARTHRITIS 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medicel examiner? Be 26. Place of Deeth (Check only one) 1□ Yes 2No Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attenuate after death. 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00015866 Bernardino (1. (Mrso, K.)) 1600 CRAIN HIGHWAY SUITESOU GLENBURNIE, MD 21061 30. Name and address of person who completed ceuse of death (ftem 23a) (Type, Print) A. ALONSO, M.L BERNARDINO 32. Registre's Signature 31. Date filed (Month, Dey, Year) Sporks MAY 0 8 2000 > Registrar

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** WARREN BIBB 5, MAY 2000 11:30 AM /Medical 4a Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 228 SUNSET DRIVE GLEN BURNIE ANNE ARUNDEL 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) Birthplaca (Steta or Foreign Country) **Funeral** Months Davs Hours 1 M 2 □ F 219-22-6289 Director NOV.3, 1927 MARYLAND Usual Rasidence of Decedant pemit. Pages 1 and 2 should be filed within 72 hours after death with the Merylend Department of Heelth and Mentel Hygiene. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinar must be notified at PAGE. 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No Directo GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 228 SUNSET DRIVE 21060 Funeral U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Was Decedant Evar in U,S. Armed Forces? 14. Raca - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 X Yas 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married 1946 21215-0020 1 ☐ Yes 2 🔯 No Specify à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1947 WHITE Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) STEELWORKER SHEARMAN Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CLAUDE BIBB ISABELLE O'SULLIVAN 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) PAULA J. BIBB- DAUGHTER 228 SUNSET DRIVE, GLEN BURNIE, MARYLAND 21060 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) MARYLAND VETERANS CEM. 15-9-00 CROWNSVILLE, MD 21. Signature of Funeral Service License 22. Nama and Address of Facility SINGLETON FUNERAL HOME, P.A., 40123 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 40 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate fnterval Betwaen Onset and Daath **Physician** fmmediata Causa (Final disaasa or condition rasulting in daath) /Medical Pa15 **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated avents resulting in daath) Last Renovascular P.O. Box 68760. the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Spinell cord infait of Vital Records, à been signe should be o 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 1 Yas 2 No 1 Yas 2 No Physician: å 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yas 2 No Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28c. Injury st Work? 28d. Describe how injury occurred After Division or Attending 1 Naturel 5 Panding invastigation s after deeth. 1 Yes 2 No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and mannar es steted.
2 Medical Examinar: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifier 5/8/00 021225 30. Name and addrass of person who completed cause of daath (Item 23a) (Type, Print) Zemal M.D. 1838 Greene Tree Rd. #245 Baltimor, Md. 21208 Stephen

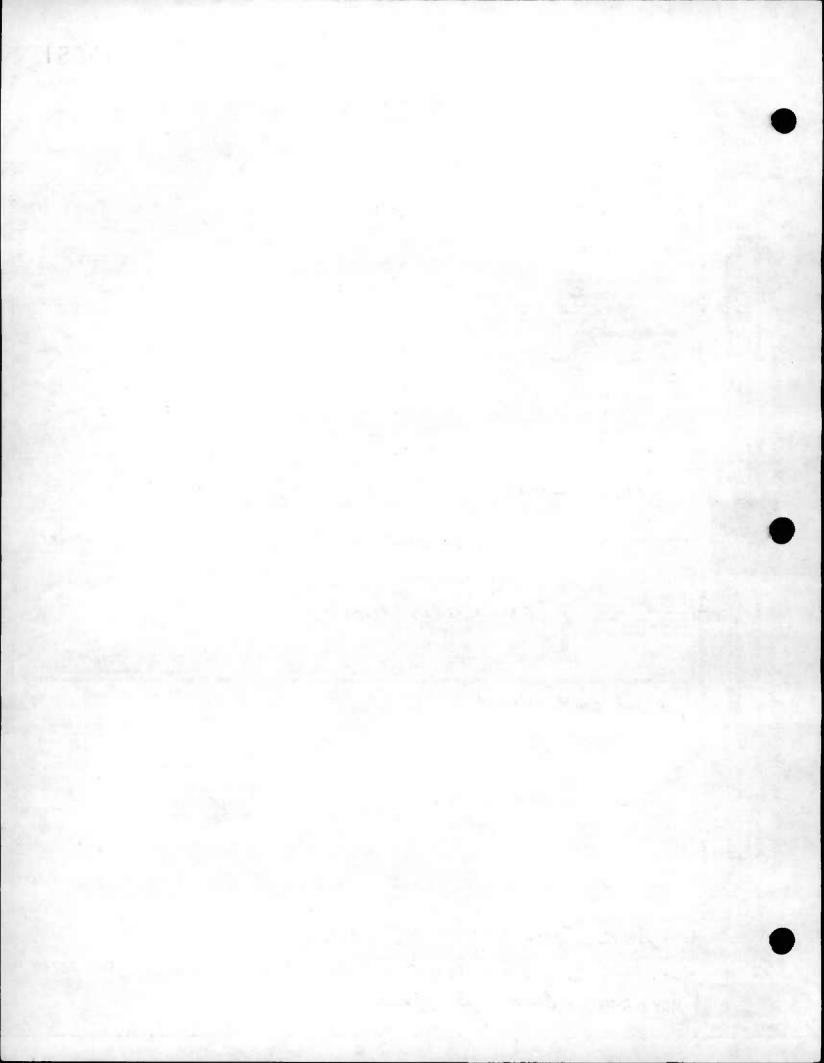
Registrar DHMH 16 Rev 6/95

State

31. Data Wad (Month, Day, Year)

MAY 0 8 2000

32. Registrar's Signatura



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amend itm 2	State of Maryland / Department of 4a,25,26,27,29c,30 per md G783 5/8/00 yg Certificate of Control o	
Physician -/Medical	1. Decedent's Name (First, Middle, Last)  Mary Ellen Ball	2. Dete of Deeth Month Dey Year 0843
Funeral Director	49 Facility Name (If not institution, give street and number)  CHARCH COUNTY MEMORIA HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 You Months Da	ab. City, Town, or Location of Death  OAKAN  Bear If Under 24 Hrs. 8. Dete of Birth 1975 Hours Min. 07-05-1919  We St Virgin:
lanyland ahow ed et	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location	10d. Inside City Limits XXYes 2 □ No
offer death with the Maryland r Name 23e or 28e-f show niner must be notified at Funeral Director	WV.         Tucker         Davis           10e. Street and Number         10f. Zip Coc           P.O. Box 183         2626	de 10g. Citizen of Whet Country?
3 2 5 F	1.0. 20 200	of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indien, Bleck, White, etc.
within 72 one. than the Weden	15 Decedent's Education 16a Decedent's Usual Oc	ccupation 16b. Kind of Business/Industry tired)
yland build be file Mental Hymeral Hymeral cuts afte event.	17. Fether's Name (First, Middle, Last) Grandville Marcella Luzader	18. Mother's Name (First, Middle, Maiden Surneme) Sara Melvina Greenleaf
Ma nd 2- lift at 27 la	Howard Ball P.O. Box 2	
E Sett	1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)    Commetter, Cremetory or other Davis Cemeter	ry 4-19-00 Davis, WV.
Baltl pemit. Departmingorta eny Inju		funeral Home ox 186 Davis, WV.26260
ceta be avacuted physician and sthe burial-transit	shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Intervel Between Onset end Death
s, P.O. Box ( se that the death certificated by the attending be detached for use e.  by Physician/Me	that initiated events resulting in death) Last  Due to (or es e consequence of):  d.  Pert II. Other significant conditions contributing to death but not resulting in the underlying cause	1 Yas 2 No 3 Probably 4 Unknown
Recor	E replugatly, retira	24a. Was an autopsy performed?  24b. Were eutopsy findings available prior to completion of cause of deeth?
Vital Iclan: The certificate rector, pa	25. Wes case referred to medical examiner?  1   Yes 2   No	26. Place of Death (Check only one)  Other: 4   Alumina Name 5   Parithage 5   Other (Secriti)
DIVISION Of V To the Hospital or Attanding Physic within 24 hours after death. To the Funerel Director: After this or completely filled in by the funeral dire Medical Certification: To	27. Manner of Death 1 ☑Naturel 5 ☐ Pending (Month, Day Year) 28b. Time of lnjury 28b. Time of lnjury	thjury et Work?  28d. Describe how injury occurred  Work?  1 Yes 2 No
he Hospital in 24 hours in the Funeral plately filled edical Co	29a. Certifier (Check only  Medical Examiner: On the basis of examination end/or investigation, in mand manner steted.	the time, date end place, end due to the ceuse(s) and memer es steted.  In a steted the time, date and place, end due to the ceuse(s)
		29d. Date signed ( <i>Month</i> , <i>Dey</i> , <i>Year</i> )  5568  4-/6-00
State Registrar	Garrett County Memorial Hospital Oakland, Maryland 31. Date filed (Month, Day, Year)  MAY 0 8 2000  Security May 1 32. Registrar's Signature	

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	Certificate of	Death Reg. No.
Dhysisian	Decedent's Neme (First, Middle, Last)	2. Dete of Deeth  Month  Dey  Yeer  3. Time of Deeth
Physician /Medical	GEORGE Brown	MAY 5 2000 12:40 AM
Examiner		4b. City, Town, or Location of Deeth 4c. County of Deeth
*	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	15altmore MA  If Under 24 Hrs. B. Date of Birth 9. Birthplece (State or Foreign
Funeral Director	212 - 74 - 2962 1⊠ M 2□ F 42 Yrs. Months Deys	Hours Min. April 12, 1958
/lend	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
to lead	MD N/A Baltimore	15 Yes 2 No
lei Hygiene. d other than 'natural', or teme 23e or 28e-f show event, the Medical Evantainer must be notified at Be Completed by Funeral Director	10e. Street and Number  430 Ross Croft Ave 2127	10g. Citizen of Whet Country?
Ter.		ispenic Origin? (Specify Yes or No- en, Mexican, Puerto Rican, etc.)  14. Raca - American Indien, Black, White, etc.
Events Events by Fu	1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give 1 Yes 2 No No Year or Detes:	Specify: Black
'natural', edical Exa leted by	15. Decedent's Education 16a. Decedent's Usuel Occup (Specify only highest grade completed) (Give kind of work done	petion 16b. Kind of Business/Industry
tel Hygiene. d other than "naturn avent, the Medical. Be Completed	Florester (Caracter (Carac	d) 0 1
Co Proje	12 + Security OF  17. Fether's Name (First, Middle, Last)	FICET LAW ENTORCEMENT  18. Mother's Name (First, Middle, Maiden Sumeme)
I Health and Mentel Hygiene.  tem 27 is marked other than other treumatic event, the M To Be Comp	IIN K	Λ/Λ Λ
is marker sumatic	19e. Informent's Neme/Relationship (Type, Print)  19b. Mailing Address (Street	end Number or Rurel Route Number, City or Town, State, Zip Code)
ith ar	Navcy Sligh-Smith-Sister 430 Rosecroft	A 11 A.S.
f Health Item 27 other tr	20e. Method of Disposition 20b. Plece of Disposition (Neme of	Date 20c. Location - City or Town, State
Department of Health moortant: If Item 27 any Injury or other tr	1 Description 3 Removel from State 4 Donetion 5 Other (Specify)  At 210N CEMETE	
Department mportant: if my injury o ance		sss of Fecility Gary P. March tweed Home
SEE S	I had I had Battimore	MD 21229, 270 FredHilton Pass
5 N/ 8	23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying shock or heart failure. List only one cause on each line.	
nysician	or neer tailure. List only one cause on each line.	Intervel Between Onset and Death
Medical	Immediate Cause (Final disease or condition  Acute Myocova	dial Interction House
xaminer	resulting in deeth)  Due to (or es e consequenca of):	
Sit Sit	Delated cas	dio myohally years
physician end s the burial-transit edical Examiner	Sequentially list conditions, fireny, leading to immediate	
buria	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	yeous
physicials the burner of the b	resulting in death) Lest  Due to (or es e consequence of):	
attending pl	d	
d by the attend letached for us.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gir	ven in Pert I. 23b. Did tobacco use contribute to the cause of deat
igned by the a be detached i	Part II. Other significant conditions contributing to death out not resulting in the underlying cause gir	1 Yes 2 No 3 Probably 4 Denkno
bed to det	Obesily	
cate has been signe page 2 should be c		24a. Wes en eutopsy performed?  24b. Were eutopsy linding: available prior to completion of cause of deeth?
ate has been signed by the attending physician end page 2 should be detached for use as the bunial-transit Completed by Physician/Medical Examir		1 Yes 2 No
	25. Wes case referred to medical	26. Plece of Deeth (Check only one)
his cer il direc	examiner  1 Pres 2 No  Hospitel: 1 Inpatient 2 FR/Outpatient 3 DOA Ot	ner: 4 Nursing Home 5 Residence 6 Other (Specify)
in Pera	27. Menner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury Wo	ry et 28d. Describe how injury occurred rk?
in 24 hours aftar deeth.  The Funeral Director: After to pletely filled in by the funeral edical Certification:	2 ☐ Accident investigation M 1 ☐	Yes 2□No
within 24 hours after deeth. To the Funeral Director: At completely filled in by the fur Medical Certification	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
Ce Ce		
Fune lely fil	29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my of	
thin 2 mple	one) end menner steted.  29b. Signeture end title of certifier (29c. Licen:	se number 29d. Date signed (Month, Dey, Yeer)
¥ 2 8		0610 May 6, 2000
N	7.11(0 0(0:0:1)	
80	30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)  MOHAMMAD SALEEM ST. AGNES HOSP.	160 CATON AVE, BALTIMORE
X	31. Dete filed (Month, Day, Year) 22 Registrer's Stineture Sports	MD 21264-2544.
State	31. Dete filed (Month, Day Year)	

ROWN, M

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EORGE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 24a per phys. G783 5/8/00 yg Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death SOARD Month IRGINIA **Physician** 11:47A-M 2000 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bon Secours Hospital Baltimore

If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) N/A If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 M 2 F Months Deys 220-30-1026 Director July 4, 1915 Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore Director 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1100 N. Gilmore Street 21223 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dafes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify. Black 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic cleaning 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Willie Tindley Ella Predeaux 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Clara Purnell/cousin unknown 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removel from State 4 ☐ Donafion 5 ☐ Other (Specify) In State onald S. Wade <sup>22</sup> Name and Address of Fecility Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease, or complications shock, or heart feilure. List only one cause ons thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, use on each line. Approximete Intervel Between Onset end Death Physir ian Immediate Cause (Final disease or condition resulting in death) /iliedical Examiner Physician/Medical Examiner DECUBTI Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were eutopsy findings available prior to FlooMahan 24a. Was en eutopsy completion of ceuse of deeth? emeuha 1 Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 🗌 Yes 2 No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Fureral Director: Attenthis certificate has been signed by the extending physician and completely filled in by the Innerial director, page 2 should be deteched for use as the burlei-transit of Vital Records, P.O. Box 68760, Division

pernit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylar Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examinate must be notified at

Baltimore, Maryland 21215-0020

director, page 2 should be detect

4 - Homicide

29a. Certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

critifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29b. Signate of certifier

29c. License number

29d. Date signed (Month, Dey, Yeer)

Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

300 ARMORYPLAS BALIMO2120), Prabhakar M.D 31. Date filed (Month, Day, Year)

State Registrar

Medical

/32. Registrer's Signeture MAY 0 8 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. dent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month 5 **Physician** 42-Eacility Neme (If not institution, give street end number) /Medical wn, or Location of Death 4c. County of Deeth Examiner Hosp 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days 29-10-954 Hours Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside/City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1⊠Yes 2□No **Funeral Director** reet end Number 10g. Citizen of Whet Country? itams 23a Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours efter 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 5 (K Saltimore, Maryland 21215-0020 ricar 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced anerica Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1,4or 5+) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is merked other any Injury or other traumetic event, once 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print)( Mailing Address (Street and Nymber or Rural Route Number, City or ltimore 4021217 20b. Plece of Disposition (Neme of cemetery, crematory of other plece) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4. Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Gulmor Approximate Intervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. **Physician** /Medicai Immediate Cause (Final disease or condition resulting in deeth) n onk Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760 Due to (or es e consequence of): P.O. Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Dehy draka 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy ma/nutrita 1 ☐ Yes 2000 1 Yes 2 No 25. Wes cese referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Certification: To Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 i POA this Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Affect 1 Watural 5 Pending investigation 1 Yes 2 No after death 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral Medical 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier 24 TOTAL 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) 004832 dende hope uning. 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

ROLENDI

31. Date filed (Month, Da

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SABUNDAGO.

32. Registrar's Signature

W. Baltinon St. Bosto ma 2/223

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 24a per phys.G783 5/8/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Facility Name (If not institution, give street end number) 2:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVENWOOD NURSING HOME BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
July 15, 19 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Deys Months 50 Yrs. Director 577-66-6701 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow **Funeral Director** MD N/A Baltimore 1 Yes 2 □ No 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? from 23s or 2 from must be n 501 W. Franklin Street 21201 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or Nema 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiana. If them 27 is marked other than "natural", or iter any Injury or other traumatic event Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 🗓 No Specify: Be Completed by Specify: black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unk unk unk unk Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) unk Annie Lee Robbins 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anne Black/cousin unknown 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Euneral Service Licensee Wade, Divector <sup>22</sup>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. 23a. Part1. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) M

/Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneati director, page 2 should be deteched for use as the burnel-transit

P.O. Box 68760.

Division of Vital Records,

5/00

Howard

nouch

Be Completed by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Hap	wither alaboras out	
Det.	Due to (or es e consequence of):	
CU	mosis of hiver	
11	Due tation as a consequence of):	
TIED	Stells	
4	Due to (or as a consequence of):	

Part III. Other significant conditions co	ntributing to death but not re-	sulting in the underlyin	Scaules given in Part I.	23b. Did tobacco use co	ntribute to the cause of death
FICACITE	1 MAN		z+Will	24a. Was en eutopsy performed?	24b. Were eutopsy findings availeble prior to completion of ceuse of death?
of Manager of and the addition				1 ☐ Yes 2 ₹ No	1 Yes 2 No
25. Was case referred to medical examiner?  1  Yes  No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetient 3	Other: 0	eeth <i>(Check only</i> one) Home 5□ Residenca 6 □Oth	ner (Specify)
27. Manner of Deeth Natural 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occur	
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, fact	ory, office	28f. Location (Street end Numb City or Town, Stete)	per or Rurel Route Number,
29a. Certifier (Check only one) Certifying Phy	sician: To the best of my known or the basis of examine end manner stated.	owiedge, deeth occurre ation and/or investigation	ed at the time, date end plec on, in my opinion, deeth occ	ee, end due to the cause(s) end ma curred et the time, date end placa,	anner es steted. end due to the ceuse(s)
29b. Signature and title of celetion		2	9c. License number	29d. Date signe	d (Month, Dev. Year)

State Registrar 31. Dete filed (Month, Dey, Year) MAY 0 8 2000

32. Registrer's Signature

MAN DE 2000 Leaves 1st 15 th 25 states

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMEND#10c PER F.H. G783 5-8-2000 JAB 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2000 Physician ERNA COLTEN MAY 4, 12:45 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner LEVINDALE NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2XF Yrs. Director 117-28-0135 APR. 27, 1909 CROATIA **Usual Residence of Decedent** 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Haalth and Mental Hydene. Important: if Item 27 is marked other then "natural", or Nema 23s or 28s-f show any Injury or other traumatic avent, the Medical Examiner must be notified as page. FL **BROWARD** 1K Yes 2 No HALLANDALE Director HALLENDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 THREE ISLAND BLVD. BLDG 3 #504 33009 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1□ Yes 2√2 No Specify: Specify: ģ WHITE 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WATCHMAKER **JEWELRY** 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be LEOPOLD BERGER **GIOVANNA** KOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) RUTH BLOCH / DAUGHTER 1704-G MT. WASHINGTON COURT - BALTIMORE, MD 21209 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation XXRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLYWOOD MEMORIAL GARDENS 5/5/00 HOLLYWOOD, FLORIDA 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License www 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner attanding physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or es a consequence of) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Division of VItal Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 200 No 1 Yes 1 ☐ Yes 2 ☐ No carlificata 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Aursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 24 hours after deat Funeral Diractor: 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide vithin 24 hour filled in Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier

State

npletaly

(Check only

29b. Signature/and title of certifier

30. Name and address of gurnon Sou

31. Date fited (Month, Day, Year)

MAY 0 8 2000

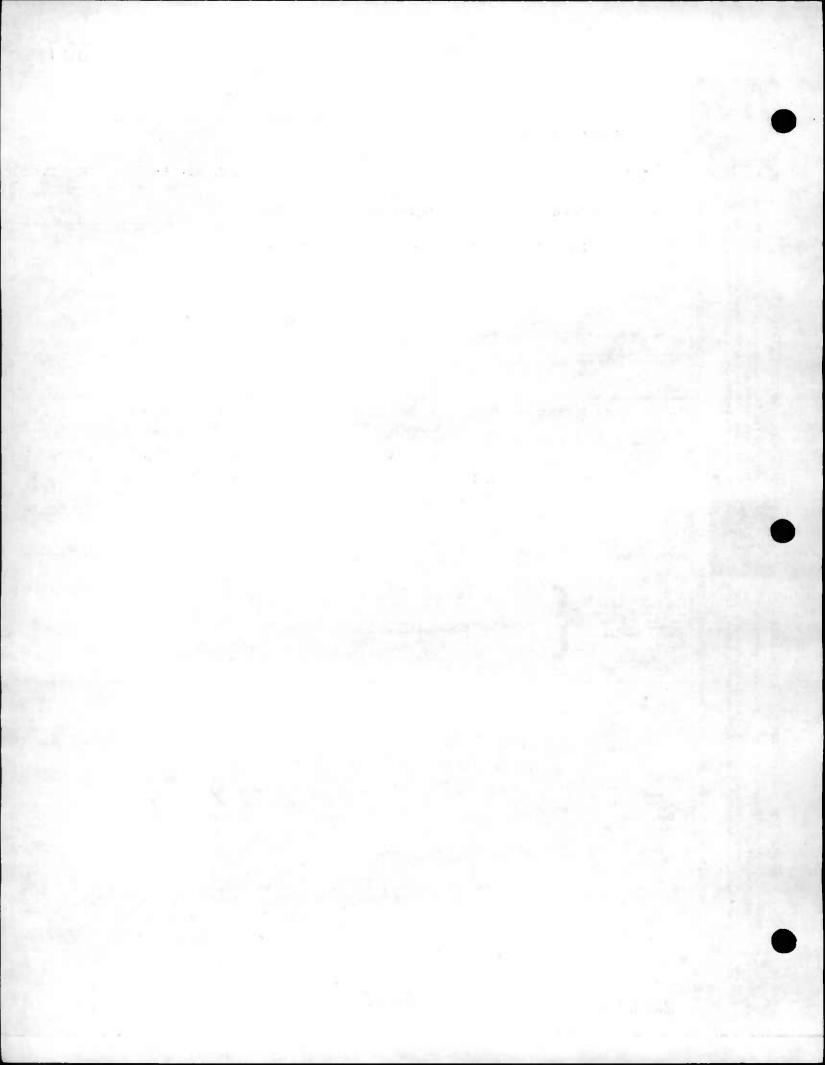
Registrar **DHMH 16 Rev 6/95** 

of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)



#### State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 5. Davis -Ouise MAY 2000 /Medical 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner tospita hanham Juctors ff Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months 1 M 204 Yrs. 265-78-4369 Director 1906 Florida Stirrup Usuel Residence of Decedent death with the Maryland 10a Stete 10c. City, Town or Location 10b. County show event, the Medical Examiner must be notified at Funeral Director Fla 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 6 335 331 3 4.5.4. Herns 23a 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Haalth and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or has any injury or other traumatic event. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: Black Specify: Be Completed by 3 Widowed 4 □ Divorced Yeer or Detes: Decedent's Usuel Occupetion (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) teacher 12 Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symeme) otte 19b. Mailing Address (Street and Number or Rurel Poute Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Pn) Par 6913 Barid grandson Harrum altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete tr Burial 2 Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cem 5-12-2000 22. Neme and Address of Facility 21. Signeture di Funeral Service Licenses Serve 4c 1201 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel Cardionyopathe diseese or condition resulting in death) Examiner Due to (or es e consequenca of) the buriel-transit The law requires that the death certificeta be executed Due to (or es a consequence of): Box 68760. physiclan

Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebro vogalor Disease þ 24a. Wes en eutopsy performed?

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Medical Certification: To Be Completed Bilatern Pleural Effusions

24b. Were eutopsy findings available prior to completion of cause of deeth?

1 Yes 2 No 26. Plece of Deeth (Check only one)

1 ☐ Yes

Approximete Intervel Between Onset and Death

3. Time of Deeth

Birthpleca (Stete or Foreign Country)

10d. Inside City Limits

1 Nes 2 No

5:00 pm

Yee

X21

25. Wes case referred to medical examiner? Hospitel: 1 Yes 2 No 1 Inpatient

5 Pending investigation

6 ☐ Could not be

2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year)

28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

28d. Describe how injury occurred 1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

27. Menner of Death

1 Maturel

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier

29c. License number 039550 29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Forbes Blud. Lanham Jr. m.O. 4850 Wd. 20706 George Hasjar,

Registrar

31. Dete filed (Month, Dey, Year) MAY 0 8 2000

32. Registrer's Signature

P.0.

of Vital Records,

Division

certificate has

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Ji Director: After this ed in by the funeral d After this

To the Hospital or within 24 hours aft To the Funerei Di

filled in by

plately

or Attending Physician:

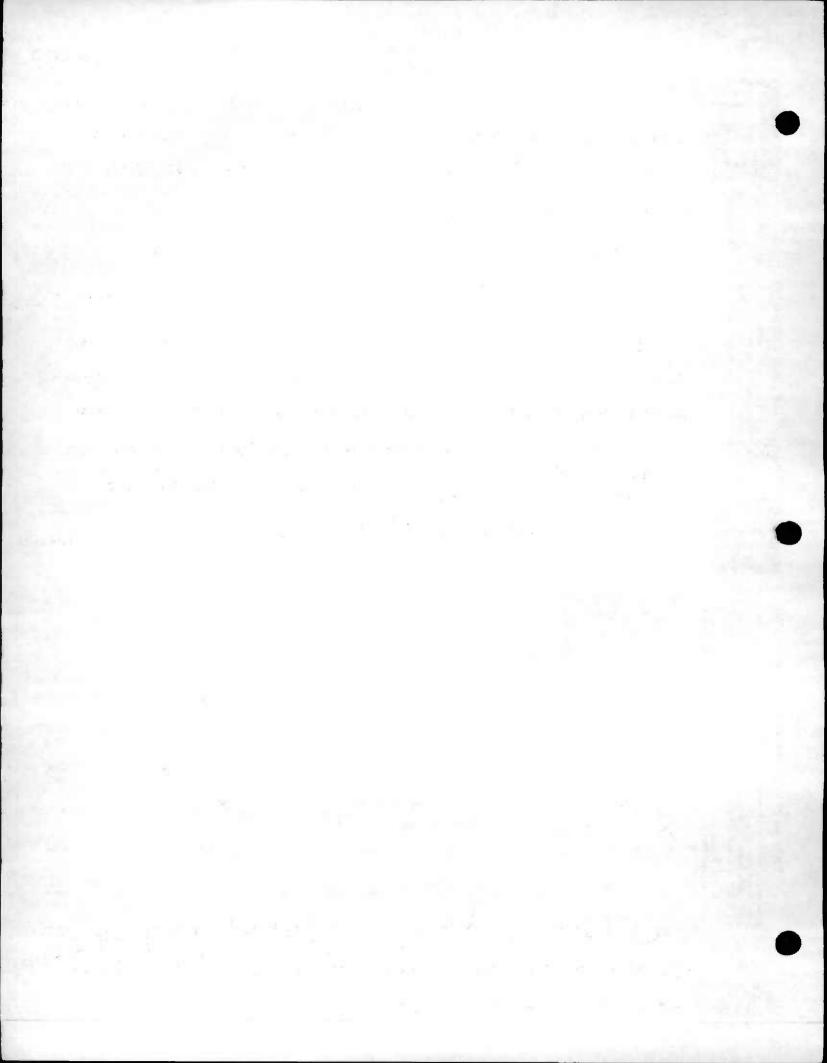
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 4, JOSEPHINE 2000 DiLAURO MAY 5:15 AM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8148 QUARTERFIELD FARM DRIVE SEVERN ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 X F Hours Director 212-30-0265 65 AUG. 3,1934 PENNSYLVANIA Usual Residence of Decedent death with the Maryland show 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Director MARYLAND ANNE ARUNDEL SEVERN 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8148 QUARTERFIELD FARM DRIVE 21144 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after to Dependent of Healin and Mental Hygiene. Important: If ftem 27 is marked other than "natural, or ften any Injury or other traumetic event, the Medical Experiment 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SUPERVISOR CHEMICAL COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be STEPHEN PLASAJ HELEN BANKOVIC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT DiLAURO- HUSBAND 8148 QUARTERFIELD FARM ROAD, SEVERN, MD 21144 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS CEM. 2000 BALTIMORE, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility SINGLETON FUNERAL HOME, PA. 401234 1 SECOND AVENUE, S.W., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Approximate Interval Between Onset and Death Physician 8 months Immediate Ceuse (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as e consequence of): Physiclan/Medical Examiner The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last buriel-tran Due to (or as a consequence of): ettending physiclan for use es the burie Box 68760 Due to (or as a consequence of): P.O. ed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 2□ No 3 Probably 4 Unknown been signed be should be detr Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed pege 2 s certificete hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 5. NIMM AGADDA Harbor O 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month May 3. Elizabeth Anna Dietz 2000 9:20 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium

If Under 1 Year

10f. Zip Code

21093

1 Yes 2 No Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Neme end Address of Fecility

Stage Dementia

28c. Injury at Work?

1 Yes 2 No

Days

Months

7. Age (In yrs. last birthday)

Yrs.

Timonium

Hostess

17005 Villa

20b. Plece of Disposition (Name of cemetery, crematory or other place)

Due to (or es a consequence of):

Due to (or as a consequence of):

10c. City, Town or Location

1□M 2ØF

Eastridge Road

12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Hart

If Under 24 Hrs.

Hours

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Glen

Rosina

Ruck Towson Funeral Home, Inc.

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

Dulaney Valley Mem. Gards. 5-6-00 Timonium, Maryalnd

8. Dete of Birth (Month, Day, Year)

6-5-1910

18. Mother's Name (First, Middle, Maiden Sumeme)

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximete Intervel Between Onset end Death

1 ☐ Yes 2 No

Maryland

10g. Citizen of Whet Country?

U. S. A.

Specify: White

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

23b. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

24b. Were autopsy findings eveilable prior to

completion of cause of deeth?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 ☐ No

1 Yes 2 No

28d. Describe how injury occurred

24a. Wes an eutopsy performed?

Kreppel

Drive, Los Gatos, Ca. 95033

14. Race - American Indien, Black, White, etc.

Thompson's Restaurant

**Physician** /Medical Examiner

parmit. Pages 1 and 2 should be illed within 72 hours after death with a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 2 enty injury or other traumatic event, the Medical France. 21215-0020 Baltlmore, Maryland **Physician** /Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be associated within 24 hours still death.
To the Fueral Director After this certificate has been signed by the ettending physician and completely filled in by its investi director, page 2 should be deteched for use as the buriar-transit P.O. Box 68760, cate has been signed by the a pega 2 should be detached it Division of Vital Records,

Stella Maris Hospice 5. Social Security Number **Funeral** 217-12-6487 Director Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore Director 10e. Street and Number 2305 Funeral 11. Marital Status 1 Never Married 2 Married þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) 8 John 19a. Informant's Name/Relationship (Type, Print) Mr. John P. Dietz (Son) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last à Completed

8 Certification: To Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier

1 Natural 3 Suicide

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannerof Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

D43725

1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated. 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMUUD 201-109 Buck River Nocle Roul Bulhoure MD 21221 31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

MAY 0 8 2000

32. Registrar's Signeture

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

ments of the second

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

S	State of Maryland /	Department of Health and	Mental Hygiene	466
		Certificate of Death	Reg. No.	
Last)	James Edward	Duncan	2. Date of Death Month Day Year	3. Time of

**Physician** /Medical Examiner

**Funeral** Director

28a-f ahow 'natural', or items 23a or the Medical Examiner must be

permit. Pegas 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or hea any injury or other traumatic event, the Mexical Ferral **Physician** /Medical

altimore, Maryland 21215-0020

Examiner physicien and s the burial-transit Box 68760 certificate be 88 esn P.0. 2

Examine

Physician/Medical

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Completed

Be

Certification: To

edicai

2 has certificate To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica

Division of Vital Records,

Registrar

Anne Nidic Mary 31. Date filed (Month, Day, Year) MAY 0 8 2000 State

29b. Signatura and titla of cortifian

MO

28b. Time of Injury

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

00052928

29d. Date signed (Month, Dey, Year)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

H Blud Bo. Home Md 21222 1792

May 3, 2000 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Dunda1k 1963 Merritt Blvd. If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Days Hours Months 113M 2□ F Yrs Nov. 25,1928 219-10-6357 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County Dunda 1k Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1963 Merritt Blvd. 21222 United States Funeral 14. Race - Americen Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Was Decedent Evar in U,S. Armed Forces? 11 Marital Status 1 (2 Yes 2 □ No If Yes, Give Year or Datas: 1948-52 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementery/Secondary (0-12) College (1-4or 5+) Police Department Detective 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 96 Edith Pauline Worth Herman Franklin Duncan 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1963 Merritt Blvd. Dundalk, Maryland Tracy L. Carver (Daughter) 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 5/6/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Ixsuas

23a. Pert / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finel disease or condition resulting in death)

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Menner of Death

1 Delatural

3 Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

2 Accident

1. Decedent's Neme (First, Middle,

Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onsat and Death

Hear ongestive Due to (of es e consequence of):

Coronary Due to (or as a consequence of)

28c. Injury at Work?

Due to (or as a consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1-ailure

28a. Dete of Injury (Month, Dey Year)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□

28d. Describe how injury occurred

10:09AM

Baltimore

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 TYes 2K No

Maryland

White

21222

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Nama and address of person who completed cause of death (I)em 23a) (Type, Print)

MO 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

No. 3 - - No. I page o YAI

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Yeer **Physician** Zelda tranklin 10:13 AM 2000 4b-Oity, Town, or Location of Death /Medical Fecility Name (If not institution give street end number) 4c. County of Deaff Examiner Birthplace (State or Foreign Country) **Funeral** 10 M 200 F Days Director ebruara a permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Important of Health and Mental Hygiene. Important: I frem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event. Its Marians is 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 MYes 2 □ No Director 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funerai Was Deceder: Armed Forces? Yes 21 No Was Decedent of Hispanic Orlgin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: rucan 2 3 Widowed 4 □ Divorced merecan Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry y/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ALTER 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) D. MI) 21231 20a. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 00 22. Name and Address of Facility 21. Signeture of Funeral Service Licenses 38 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. MD 212 23a. Pert1. Enter the diseese, or complications that cause shock, or heart feilure. List only one ceuse on eech Approximete Intervel Between Onset end Death **Physician** /Medical Immediele Ceuse (Final disease or condition resulting in death) Examiner Examiner UNKNOWN ettending physician and for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other eignificent conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed certificete has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attanding Philithin 24 hours after death.
To the Funeral Diractor: After thi completely filled in by the funeral funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature end title of cedifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Pkwy Balto MD 21218 ebow 201 E. Universit Kichard M.D 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State Registrar 2000

DHMH 16 Rev 6/95

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day Yeer **Physician** VIICHAEL 0807 DENIOR 1056PH 05 2000 MAT \* /Medical 4c. County of Deeth 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** DALTINORG 761 KOICAC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24,1917 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** Deys Months Hours 1⊠M 2□ F Yrs. 213-07-3347 82 Maryland Director Usuel Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryle Department of Heelih end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner mant be notified at 1 ☐ Yes 2 TNo Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1936 Mountain Avenue 21234 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Biack, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No tf Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 12 Years Shipping Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Anna Brand Joseph Fackett 0 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1936 Mountain Ave. Parkville, Maryland 21234 Mr. Gary L. Fackett (Son) 20b. Placa of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Remove i from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/8/2000 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Fineral Service Licansee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) 4 7GARS BNCGR Examiner Due to (or es e consequença of): Examiner certificate be executed physician end the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury Due to (or as e consequenca of): P.O. Box 68760, ettending physician for use es the bune Physician/Medical that initiated events resulting in death) Lest Due to (or as e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the deteched 3 □ Probably 4 ☐ Unknown 1 Yes 2 No Records, ρ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Was en eutopsy Deen performed' hes 1 TYAS 2 No 1 ☐ Yes 212 No certificete Division of Vital director, Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Dimpatient 2 ER/Outpetient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigetion 1 Naturel injury 1 Yes 2 No death. Hospital or Attendi 24 hours efter death. Funeral Director: A 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) 29a. Certifier Medical end manner sta 29d. Date signed (Month, Day, Year) 29b. Signature and little by be 5/0520 05 2000 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) TAZL 46 1/6w94 32. Registrer's Signature 31. Date filed (Month, Dev. Year) State MAY 0 8 2000 Registrar

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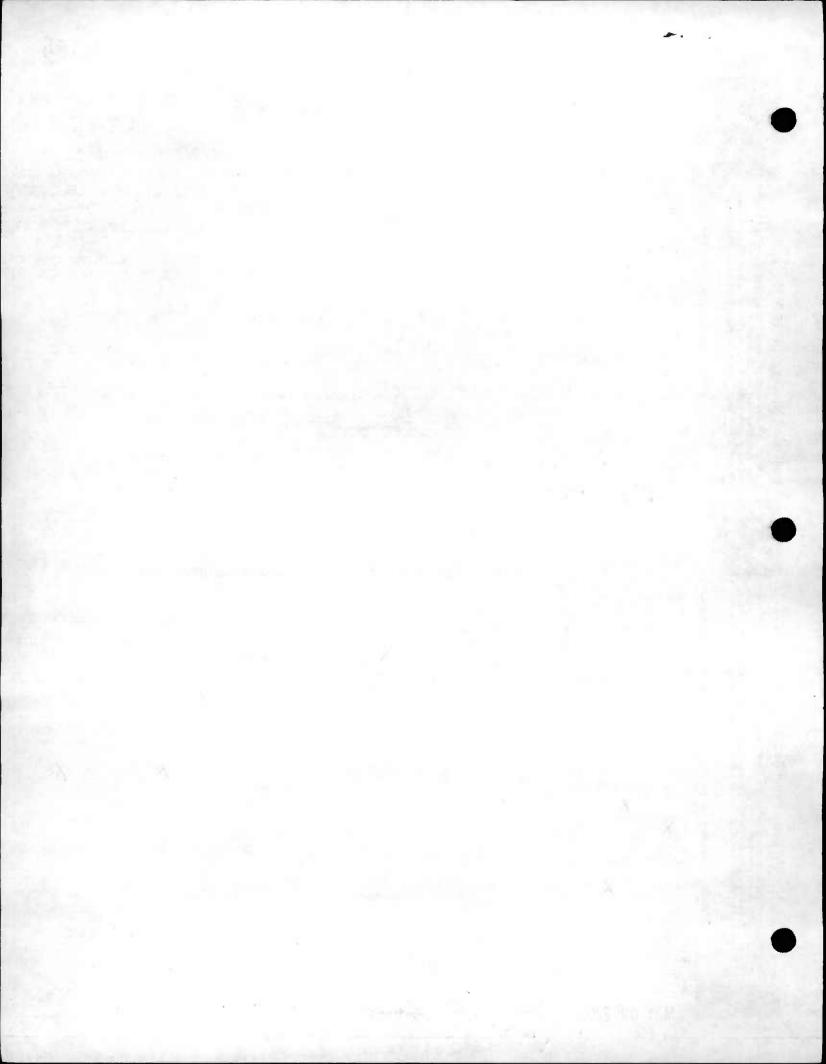
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State of Maryland / Department of Health and Mental Hygiene 00 116664

46. County of Deeth Baltimore  47. Age (In yrs. last birthday)  5. Social Security Number  1. 10					Certificate o	f Death		Reg. No.			14
48. Fixelly Name of the surface, plus states and number of the property of the	vsician	1. Decedent's Name (First, Middle, L	Last)				Month		_ Year_		
Saint Joseph Medical Center  187–34-4854 10 w 2pr   2. Age for yr. bast bringing   10 Disor Year   10 Disor Ye	Medical						M			9:00	Al
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MD Harford Fallston	eral ctor	187-34-4854	1DM 2DE		Months Dev		Min. (Month, L		Coun	lace (State try)	or For
Elementary/Secondary (p-12)   44	4			10c. City, Town	n or Location				16	Od. tnside C	ity Lin
Elementary/Secondary (0-12)	ctor	MD Harfor	rd	Falls	ston					1 Tes	24
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Trailing   Name (Prizz, Mode), Last)   10. Marrim   10. Morter's Name (Prizz, Mode), MacCon Surrame)   10. Dorotchy Foge   1.   10	by	1 Never Married 2 Merried	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Λ				in? (Specify Yes or N Puerto Rican, etc.)		ack, White,	etc.	
19. Mother's Name (First, Model), Last)   19. Mother's Name (First, Model), MacConstruction   19. Mother's Name (First,	mpleted	(Specify only highest g	completed) College (1-4or 5-		(Give kind of work dor life. DO NOT use reti	e during most	of working			dustry	
198. National Name Profession   199. Print)   198. Mailing Address (Street and Number or Rural Rouse Number, City or Town, Stale, Zp Code)   24.13 Engl. Rd., Fallston, Md. 21047   20.5 Mailing Address (Street and Number or Rural Rouse Number, City or Town, Stale, Zp Code)   24.13 Engl. Rd., Fallston, Md. 21047   20.5 Mailing Address (Street and Number or Rural Rouse Number, City or Town, Stale, Zp Code)   24.13 Engl. Rd., Fallston, Md. 21047   20.5 Mailing Address (Street and Number or Rural Rouse Number, City or Town, Stale, Zp Code)   24.13 Engl. Rd., Fallston, Md. 21047   20.5 Mailing Address of Facility   20.5 Mailing Address of Facil	ပိ	17. Father's Name (First, Middle, Las			Printer	18. Mother	's Name (First, Middle				
Sh. Informant's NemerReletionship (Tipse, Prist)  Sh. Informant's NemerReletionship (Tipse, Prist)  Sh. Informant's NemerReletionship (Tipse, Prist)  20b. Method of Disposition 1D Burial 2 BigCementon 3   Demonstration State 4   Demonstration State 4   Demonstration State 4   Demonstration State 4   Demonstration State 5   Demonstration State 4   Demonstration State 5   Demonstration State 5   Demonstration State 4   Demonstration State 5   Demonstration State 6   Demonstration State 6   Demonstration State 6   Demonstration State 7	o B	Walter J. Marm				Dor	othy Foge	1	·		
206. Method of Disposition   206. December	-	19a. Intormant's Neme/Reletionship	(Type, Print)	19b	. Mailing Address (Stre	et and Number	or Rural Route Num	ber, City or Town	n, State, Zip	Code)	
Sequentially list conditions such considering in death but not resulting in the underlying cause given in Pert I.   23b. Did tobacco use contribute to the cause of a consequence of):		Shirl Grable / h	nusband	24	413 Engle R	d., Fal	llston, Md	. 21047			
A   Docation   Society   Hilltop Service Corp   5/5/00   Towson, MD			□Romoval from State	20b. Place of cemater	Disposition (Name of ry, crematory or other p	lace)	Date	20c. Location	- City or To	wn, Stete	
Ruck Towson Funeral Home  Part Fire find disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying, such as cardiac or respiratory errest.  Approximate the mode of dying the underlying cause dying in the underlying cause given in Pert I.  1	Important: If ite any injury or of ange.			Hillto	op Service	Corp	5/5/00	Towson	n, MD		
23a. Fant: Enrolled classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a. Fant: Enrolled classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a. Fant: Enrolled classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  23a. Fant: Enrolled classes (Final disease or conditions or cause on each time.  23b. Due to (or as a consequence of):  23c. Sequentially list conditions.  23c. Enrolled classes (Final disease).  23c. Enrolled classes (Fina		21. Signeture of Funeral Service Lice	11 / 1 216		22. Name and Add	rass of Facility		1050 Y	ork Ro	ad	
RESPIRATORY FAILURE  a. Due to (or as a consequence of):  METASTATIC CARCINOMA TO PLEURA, LUNG, AND  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  Due to (or as a consequence of):  BONE, FRIMARY LUNG  Cause (Disease or Injury the instinated events resulting in death) Last  11 Yes 2 No 3 Probably 4 Unit  24a. Wes an europsy performed?  24b. Wers autopsy Industrial events of the injury of the	oi	Shake PC	och Die	CISTEL	Ruck Tows	on Fune	eral Home	Towson	, MD 2	21204	
Port II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.   Due to (or as a consequence of):   BONE, PRIMARY LUNG   BONE   BONE, PRIMARY LUNG   BONE, PRIMAR		23a. Part 1. Enter the disease, or con shock, or heart tailure. List on	mplications that caused by one cause on each line	the death. Do r	not enter the mode of d	ying, such as c	ardiac or respiratory	arrest,	l i	Approxime Interval Be	te twee
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Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause of death of		if any, leading to immediate	that initiated events The to (or as a consequence of).								_
24a. Wes en eutopsy performed?  24b. Wera eutopsy find available prior to completion of cause of death?  1	calE	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	C						- 1		
24a. Wes en eutopsy performed?  24b. Were a eutopsy find available prior to completion of cause of death?  1	Medical	that initiated events	c						1 1		
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25. Wes case referred to medical examiner?  1	slan/Medical	resulting in death) Last	C	Oue to (or as a c	consequence of):	given in Pert I.	1	1			
25. Wes case referred to medical examiner?  1	by Physician/Medical	resulting in death) Last	C	Oue to (or as a c	consequence of):	given in Pert I.	24a. We	Yes 2□ No	3 Prob	era eutopsy eilable prior mpletion ot	Unk findir
27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29b. Signeture and addrass of person who completed cause of death (Item 23a) (Type, Print) 28c. Injury at Work? 1   Netural Work? 1   Yes 2   No 28d. Describe how injury occurred 28d. De	by Physician/Medical	resulting in death) Last	C	Oue to (or as a c	consequence of):	given in Pert I.	24a. We per	Yes 2□ No s en eutopsy formed?	3 Prob	era eutopsy eilable prior mpletion ot death?	finding to cause
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)  29a. Certifier (Check only one) 29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.  29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	Be Completed by Physician/Medical	Pert II. Other significant conditions  25. Wes case referred for medical	c	Oue to (or as a c	consequence of):	26. Place 6	24a. We per	Yes 2□ No s en eutopsy formed?  Yes 2□ No	3 Prob	era eutopsy eilable prior mpletion ot death?	finding to caus
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  LOPE T. VILLA, SR, M.D., 76Ø1 OSLER DRIVE, TOWSON, MARYLAND 212Ø4	Certification: To Be Completed by Physician/Medical	25. Wes case referred to medical examiner?  1 Yes 25 No  27. Menner of Death 1 Neturat 5 Pending investigate at Certifier (Check only 2 Medical Examiner)	Hospital: 1 Inpatien  28a. Dete of trijung (Month, Dey)  28e. Place of Injun building, etc.  Physician: To the best of iminer: On the basis of iminer:	t not resulting in  t 2 ER/Ou  y  year) 28b. 1  in y - At home, fa  (Specify)	tpatient 3 DOA time of niury M 1 mm, street, factory, office, death occurred at the	26. Place of the control of the cont	24a. We per 1 Col Death (Check only sing Home 5 Recorded to 28f. Location City or Toplace, end due to the	Yes 2 No s en eutopsy formed?  Yes 2 No one) sidence 6 Or how injury occu (Street and Num own, State)	3 Prob 24b. We ave cor of a state of the results of	pably 4 para eutopsy silable prior mpletion of death?  Yes 20	findir to cause No
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Kathleen Elaine Gillman 3:12 p.m. May 3, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Nursing Center Towson Baltimore Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 15, 194 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign Country) Funeral 10 M 20 F Months 215-42-7894 55 Yrs. Director 1944 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No N/A Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3311 Rosekemp Avenue 21214 United States 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status filled within 72 hours after 1 Never Married 2 Married 6 Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Market Analyst Insurance permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked oth-any Injury or other traumatic svent ADS. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å William Sherwood Walton, Sr. Mary Regina Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Palmyra, VA William S. Walton, Jr. / Brother 16 Xebec Road 22963-2745 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1) Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 5/6/2000 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael Canapp 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician Central nervous system by uphom # Immediate Cause (Final disease or condition resulting in death) /Medical / month Examiner Physician/Medical Examiner ettending physicien and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pege 2 should be de Completed by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy performed? certificate 1 ☐ Yes 2 ☐ No e 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpalien 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) (+05/10 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Matural ne Hospital or Attending n 24 hours efter death. The Funeral Director: After pletely filled in by the fun 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

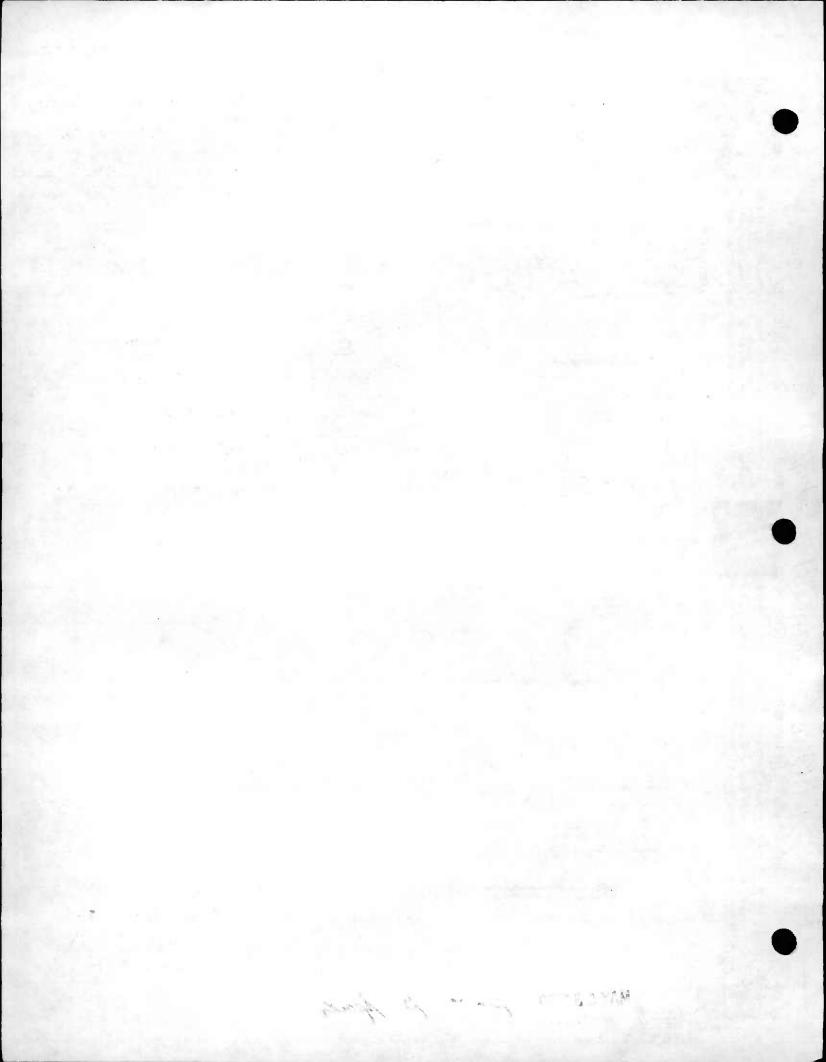
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifie (Check only one) To the I within 2 To the F 29b. Signature and life of certifier 29c. License number 29d. Dete signed (Month, Day, Year) N. Charles St. Rollo Md 21204 and address of person who completed cause of death (Item 23a) (Type, Print) 6701 32. Registrar's Signeture

**DHMH 16 Rev 6/95** 

State

Registrar

2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

lagnolia Hawkins

Box 68760,

P.O.

Records,

Division of Vital

Registrar

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1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth **Physician** a 2000 Magnolia Hawkins /Medical ility Neme, (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ary land 8. Date of Birth (Month, Day, Yeer) If Under 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 K F Yrs 247-42-6469 Director 09 S.C Usuel Residence of Decadent with the Maryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is merked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner insist be notified at 1X Yes 2 No Director Baltimore MD NA 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 21215 3632 Glengyle Funeral Ave 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes A No If Yes, Give Year or Detes: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: \$ 3€Vidowed 4 Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within rent of Haalth and Mantal Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10th grade Disabled Disabled 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Marie Allen Alex McMillion 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Ellerbee Item 27 i 624 S. Kalmia Ave, Highland Springs, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date Important: If the XIXBurial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Department of Garrison Forest Vet. 5-10-00 Owings Mills, 22. Name end Address of Fecility March F/H WEst 4300 Wabash Ave, Baltimore Md 21215 ations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit The law requires that the death certificata be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequença of): Physician/Medical Due to (or es e consequence of): 88 attending for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuee of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? should should 24e. Wes en eutopsy Completed is cartificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ector: / 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) ò Direc 4 Homicide Hospital or /
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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of	f Death	Re	eg. No.	14000			
hysician	1. Decedent'a Nama (First, Middla, Last)		2. Data of Daet Month	Day Year	3. Tima of Death			
ledical	GEORGE MELVIN HUNT		MAY	05 2000	4:30AM			
miner	4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Lo	ocation of Deeth	4c. County of Dea				
_	GREATER BALTIMORE MEDICAL CENTER	TOWSON	T	BALTIMOR				
	5. Social Security Number 217-18-2455  6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) 88  Yrs.  1 Under 1 Yea Months Day		8. Data of Birth (Month, Day, May 12,	Year) 9. Bir	tholace (Stata or Foraign ountry) Md.			
	Usual Rasidence of Decedent  10a. Stata 10b. County 10c. City, Town or Location				10d. Insida City Limits			
0	Md. Baltimore Lutherville				1 ☐ Yas 2 No			
Funeral Director	10e. Street and Number 10f. Zip Coda		11	0g. Citizan of What C	ountry?			
5	8515 Valleyfield Rd.	21093		USA				
•	11. Marital Status  1 □ Never Merried 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S.  Armed Forcas?  1 ☑ Yes 2 □ No  If Yas, Giva Yeer or Detas: WW—II	f Hispanic Origin? (Spuban, Maxicen, Puarto o Specify:	ecify Yas or No- Ricen, atc.)	14. Race - Ame Black, Whi				
	15. Decedent's Education (Specify only highast grada complated)  Elementary/Secondary (0-12)  College (1-4or 5+)	na during most of work	ing	16b. Kind of Business	/Industry			
Completed	12 4 Colonel			U.S. Army	<u> </u>			
Be	17. Fether's Nema (First, Middla, Last)	18. Mothar's Nam	a (First, Middla, M					
2	George Hunt	Eva		Unknown				
	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Stre							
	Mrs. Ruth C. Hunt/wife 8515 Valleys  20a. Method of Disposition (Nama of	riela ka.		IIE, MG. Z				
	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify)  Camarary, cramatory or other p  Hilltop Service C	orp. 5	/6/00	Towson, Mo				
		rass of Facility Owson Fune: rk Rd. Tow						
	71. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line.	ying, such as cerdiac	or raspiratory arra	ast,	Approximata Intarval Between Onsat and Daath			
	Immediata Causa (Final disaasa or condition	SIA			3 days			
	rasulting in daath)  Dua to (or as a consequence of):				4 days			
Examiner	UROSEPS	515		U.S.	4 days			
Xan	Sequentially list conditions, if any, laading to immadiata							
	Cause (Diseasa or injury	IDDM						
Medical	that inflated events rasulting in death) Last  Dua to (or as a consequence of):		. 15					
clan								
Jysi	Part II. Other significant conditions contributing to death but not rasulting in the underlying cause	givan in Part I.		bacco uae contribut es 2□ No 3□ F	to the cause of death?			
Dy Z	Dementia, Respiratory for Aspiration	eleve	101	98 20 NO 30 F	TODBOTY 412 OTKHOW			
Completed by Physician	Aspiration		24a. Was a perform		Wara autopsy findings available prior to completion of ceuse of death?			
E			1 □ Ye	s 2 No	1 ☐ Yes 2 ☐ No			
Be	25. Was casa rafarred to medicel axaminer?	26. Placa of Daat	h (Chack only on	a)				
9	1 Yas 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA	Other: 4 Nursing Ho	oma 5 🗆 Rasida	nce 6 Othar (Spe	ecify)			
	27. Mannar of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident invastigation  28a. Data of Injury (Month, Day Year)  28b. Tima of Injury W	jury at Vork? □ Yas 2 □ No	28d. Dascribe ho	ow injury occurred				
Serince.	3 Suicida 4 Homicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)	ee .	28f. Location (St City or Town	raat and Number or F n, Stata)	lural Routa Number,			
edical Certification:	29a. Certifiar (Check only one)  1 Certifying Physician: To tha best of my knowledga, daath occurred et tha companies of axamination and/or invastigation, in my end manner steted.							
Me		nsa number		9d. Data signed (Mon				
	Inorge N. Karllar mo DI	6189		5/5/20	00			
	30. Name and address of person who completed causa of death (Itam 23a) (Type, Print) CERCE N. KARICAR MO PA. 656	5 N. Char						
State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	/		,,,,,				

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 1466

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death May 6, 2000 **Physician** Trwin Florence 4:25 a.m. 12. /Medical 4a Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Center Baltimore City If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dev. Year) 1910 9. Birthplece (Stete or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Days 1 ☐ M 2 🖫 F 215-22-4400 Yrs Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Owings Mills 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 4 Strawhat Rd. Apt. 3 B 21117 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Saleslady Dept. Store 10 permit. Pages 1 and 2 should be file.
Department of Health and Montal Hy important: If Nem 27 is merited other any Injury or other trearmette events. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Edward B. Radeliffe Alberta A. Bek 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William E.D. Irwin - Son 38 A Bayview West, Selbyville, Delaware 19975 20b. Place of Disposition (Name of cometery, cremetery or other place)
Arlington National Cem. 20e. Method of Disposition

1 Burial 2 Cremetion 3 Removel from Stete 20c. Location - City or Town, State May 15,2000 Arlington, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility H.H. Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical Acute Renal Failure Examiner Physician/Medical Examiner Metastatic law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760, thet initieted events resulting in death) Lasf Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yae 2 No 3 Probably 4 Unknown Conjetive Heart Failure Records. 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy 1 Yes 2 PNo 1 ☐ Yes 2 No of Vital or Attending Physician: after deeth. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending 1 Neturel 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature end fitte of cariffee 29c. License number 29d. Date signed (Month, Dey, Year) 05/06/2000 D41476 30. Name end eddre person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES St. Shite 416 BALTIMORE, MD. 21204 RAYMOND W. WILSON MO 32. Degistrer's Signature 31. Dete filed (Month, Dey, Year) State MAY 0 8 2000 Registrar

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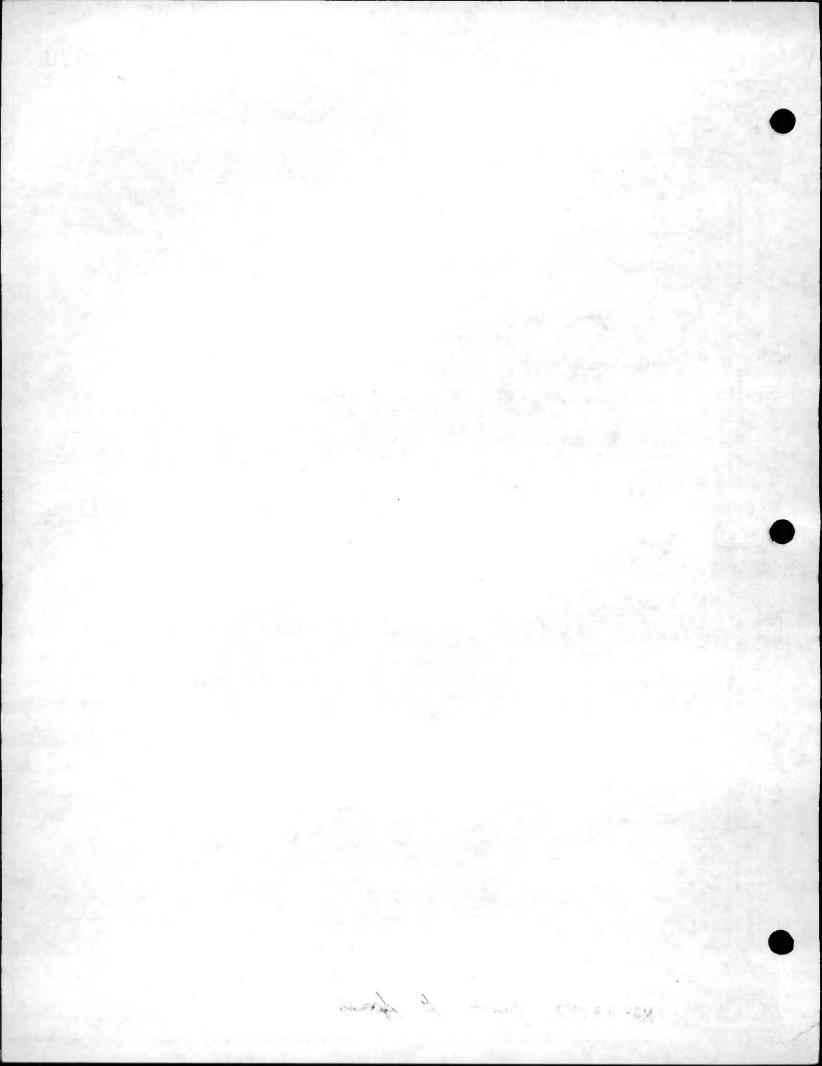
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State of Maryland / Department of Health and Mental Hygiene 00 14670

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	1. Decedent's Neme (First, Middle, Last)				Me		2. Dete of Deat Month	th Dey	Year	3. Time of Deeth
Physician /Medical	Lucille	Jefferies	3				May		2000	4:30 PM
Examiner	4e Facility Neme (If not institution, give :	street and number)			4b. City, To	wn, or Lo	cation of Deeth	4c. Count	y of Deeth	
	Union Memorial	Hospital			Balt	imo	re	N	IA	
uneral irector	5. Social Security Number 6. Security Number 220-50-1267	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Deys		24 Hrs. Min.	8. Date of Birth (Month, Dey 08-14	1 - 51	9. Birthp	hace (Stete or Foreign htry) MD
	Usuel Residence of Decedent									
art show	MD NA		ty, Town or Lo						1	0d. Insida City Limits XXYes 2□No
ar 28	10e, Street and Number			10f. Zip Code			1	0g. Citizen of	What Coun	itry?
al B	1016 Darley Av	enue		212	18			USA		
item 27 is marked other than "natural", or heme 23e or 28e-f show other traumatic event, the Medical Evanties must be notified at other traumatic event, the Medical Evanties must be notified at other traumatic event, the Medical Evanties and Purerial Director	1 Nevar Married 2 Married	12. Was Decedent Ever in U Armad Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Wes Decedent of If Yes, specify Cu	ben, Mexicar	, Puerto	ecify Yas or No- Rican, etc.)		ca - Americack, White,	
nor than "nature it, the Medical E Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	dent's Usuel Occu kind of work done DO NOT use retire	upetion e during mos	t of worki	ing	16b. Kind of B	Business/Inc	dustry
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- F	High Sch. Grad	ΝĀ	٠ ــا	P.N.	10.00.00		451	Rica		any
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antic eve To Be		swell, Sr.			Ros			okes	7,11	
trsum trsum	19e. fnforment's Name/Relationship (Ty									Code) 21213
Important: if item 27 is any injury or other tra	Sharonda Jef	feries		Norma.	l Ave	nue				
r off	20e. Method of Disposition 1X Burial 2 □ Cremetion 3 □R		Place of Dispo cemetery, crer	osition (Neme of metory or other pi	ece)	1	Date	20c. Location	- City or To	own, Stete
ary o	4 Donation 5 Other (Specify)	St	okes	Cemeter	ry 05	-06-	-2000	crewe,	VA.	
any inju	21. Signature of Funeral Service License	98	22	2. Name end Add	ress of Fecili	y Ral	ltimore	Marsi	land	21202
Eca	DI Man and	TOTAL								
	23a. Pert1. Enter the diseese, or compli	cations that caused the dea		M.C.Mai					Ave	Approximete
	shock, or heart feilure. List only or	ne cause on each line.	20			00.00	or recopilation y circ	001,		Intervel Between Onsat and Death
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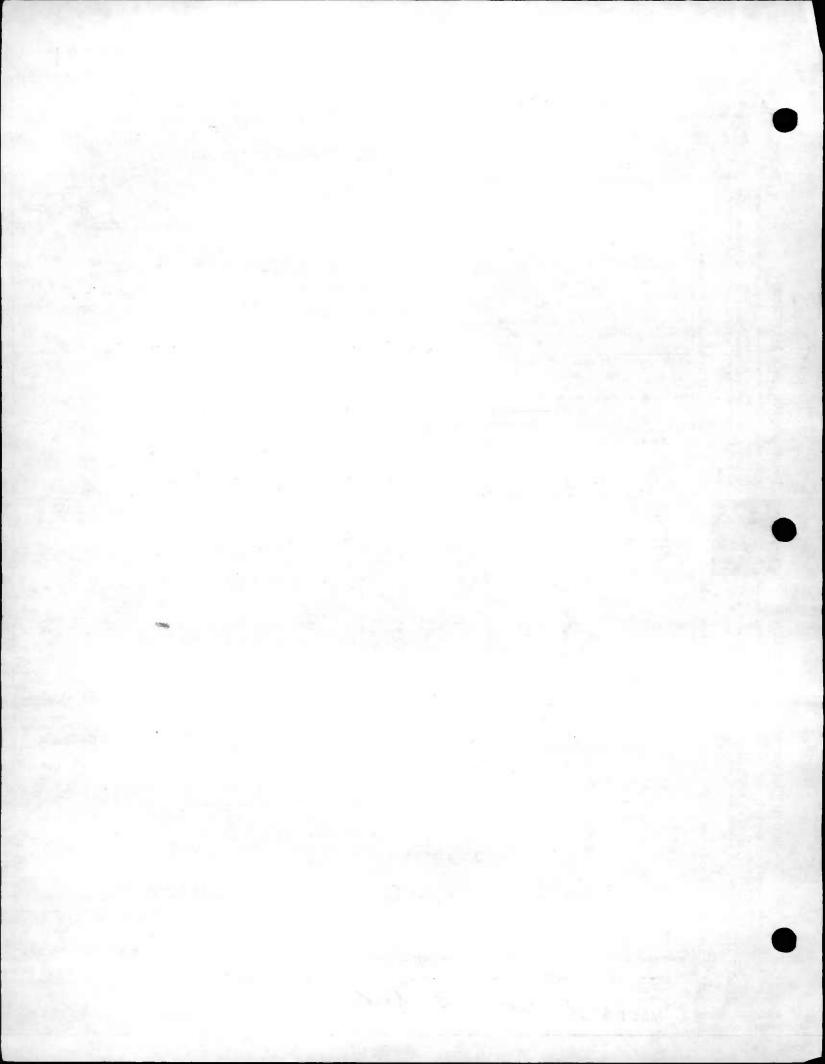
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	Decedent's Name (First, Middle, Last,	)		ertificate o	T Death	2. Dete of Deet		3. Time of Death	
Physician	Emma Catherine J	ohnson				Month	4, 200	90 4:10 pm	
/Medical Examiner	4a Facility Neme (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County of		
	Avalon Manor				Hagers	town		shington	
Funeral Director	5. Social Security Number 6. Set 184 12 3153	7. Age (In)	rs. lest birthd Yrs	Months Day	ar If Under 24 Hr	s. 8. Dete of Birth	, 1923 j	9. Birthplece (Stete or Foreign Country) Pennsylvania	
P >	Usuel Residence of Decedent  10a, Stale 10b, County	1400	Oh. Tour	- Landin					
show show			City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
vith the Ma t or 28a-f a be notitied	Maryland Baltimore	е	MICC	lle River			0		
atter death with the Manyland or them 23s or 28s-f show miner must be notitled at Funeral Director	10e. Street and Number 2234 Redthorn Rd.				220		0g. Citizen of Wi	nat Country?	
r tems 23s		12. Wes Decedent Ever in Armed Forces?	n U,S. 1	<ol><li>Was Decedent of If Yes, specify Company</li></ol>	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		- American Indien, , White, etc.	
	1 ☐ Never Married 2 ☐ Merried 3 ☑ Widowed 4 ☐ Divorced	If Yes Give					Specify:	White	
or than 'neturn', the Medical	15. Decadent's Edu (Specify only highest grade	cation e completed)	16a. De	ecedent's Usual Occ live kind of work dor e. DO NOT use reti	supation ne during most of w	orking	16b. Kind of Bus	iness/Industry	
d within 7 giene.	Elementery/Secondery (0-12)	College (1-4or 5+)			red)				
Co Francisco	10		HOU	sewife	Tala		Own Ho		
italitation and and and and and and and and and an	17. Fether's Neme (First, Middle, Last)  John Sherk				The state of the s	eme (First, Middle, I	Maiden Sumeme		
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and 2 should be flie and 2 should be flie set a marked oth er traumatic event To Be (	19e. Informant's Name/Reletionship (Ty Elsie C. Ludwig (	DAUGHTER )	650	) Welltown	n Rd. Win	Rural Route Number chester,			
pentit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "netural", any injury or other traumatic event, the Medical Exa page.  To Be Completed by	20a. Method of Disposition  1XI Burial 2 ☐ Cremetion 3 ☐ R  4 ☐ Donetion 5 ☐ Other (Specify)			sposition (Name of cremetory or other points) Mem.		Dete 0/8/2000		ore, Md.	
pemit. Departm Importa any inju	21. Signature of Funerel Service Licensee  22. Name end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221								
	John N. Du	Nousse							
Physician	23a. Far1. Enter the disease, or complished, or heart failure. List only or	ications that caused the d ne cause on each line.	eeth. Do not	enter the mode of d	lying, such es cardii	ac or respiratory arm	est,	Approximete Intervel Between Onset end Death	
/Medical	Immediate Cause (Finel disease or condition	Acı	ite M	mondi	10 IMAN	ction		6 HRS	
Examiner	Due to (or es e consetuence of):								
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at the death certified by the attending eteched for use a Physician/M	Pert II. Other significant conditions con				given in Pert I.	23b. Did to	bacco use cont	ributa to the cause of death	
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been shoul	Pne	inson's la umomà mentra		ATT.		24a. Was e periori	n eutopsy ned?	24b. Were autopsy findings eveilable prior to completion of cause of death?	
ysician: The lew is certificate has director, page 2	De	mentra				1 🗆 Ye	s 200 No	1 ☐ Yes 2 ☐ No	
siclan: Trentificate lirector, pe	25. Wes case referred to medical examiner?				26. Plece of De	eeth (Check only on	e)		
Physician: this certific rai director,	1 Yes 275 No	lospitel: 1   Inpatient 2	2 ☐ ER/Outpa	itient 3 DOA	Other: Nursing	Home 5 ☐ Reside	ence 6 Other	(Specify)	
of funeral	27. Manner of Deeth  1 A Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Tim Inju	ry V	jury el Vork? □ Yes 2 □ No	28d. Describe h	ow injury occurre	d	
tal or Attending P is after death. al Director: Attent ied in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	e of Injury - At home, ferm, street, factory, office ting, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my liner: On the basis of exam	knowledge, de ination and/o	eath occurred et the r investigation, in m	time, date end pled y opinion, deeth occ	ce, end due to the courred et the time, d	ause(s) end men ete end place, ei	ner es steted. nd due to the cause(s)	
Mec Mec	29b. Signature and title of certifier	and manner stated.		29c Line	nse number	2	9d. Date signed	(Month, Dey, Year)	
F. 2 T. 8	A						Mar	5, 2000	
X	I V				14996		1	/	
arch'	30. Name end eddress of person who co		100			01716			
VX	Dr. Zafar Malik			RD Boons	boro, MD	21/13			
State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrar's Si	D. A	pouls					

P-9

EXPIRED

EMMA JOHNSON



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #18 PER F.H. G783 5-8-00 WR. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Yeer Month May 090ahss LRENE 03 2000 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 5601 Loch Raven 4c. County of Deeth GOOD SAMARITAN HOSPITHL BALTIMORE. BLUD  $\begin{array}{c|c} \text{If Under 24 Hrs.} & \text{8. Date of Birth} \\ \text{Hours} & \text{Min.} & \text{9.2-01.} -1.93.2 \\ \end{array}$ If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 ☐ M 2 37F 68 Yrs 213-30-9432 BALTO. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21234 U.S.A 2303 PENTLAND 109 DR APT. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 12. Was Decadent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 Ves 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSING HEALTH 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surname) HELENE KEENLE ERNEST KEENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 22 YUMA CT, RANDALLSTOWN, MD 21144 TYRONE KNOX, SON 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete Date 1X Burial 2 Cremetion 3 Removel from State 5-8-00 RANDALLSTOWN KING MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) re of Fundral Service License 22 Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List on the cause on each line. Approximate Intervel Between Onset end Deeth MYOCARDIAL INFARCTION Immediate Ceuse (Final diseese or condition resulting in deeth) 1/2 hour Due to (or es e consequence of): Due to (or es e consequenca of): Due to (or es e consequence of)

**Physician** /Medical Examiner

attending physicien and for use as the buriel-transit

signed by the a

page 2 should

Hospital or Attending Physician: '24 hours efter death.'
Funeral Director: After this certifica

24 hours efter death.

Puneral Director: After this letely filled in by the funeral

To the Hospi within 24 hour To the Funer completely fill

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Be L<sub>o</sub>

Certification:

edical

The lew requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

**Director** 

the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at another.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest

3 Suicide

Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. DILATIONAL-ANERYSM OF AORTA HYPERTENSION CHRONIC OBSTRUSTIVE DISEASE; OBESITY

23b. Did tobac	co use co	ntribute to the co	ause of death?
1 Tyes	2 🗆 No	3 Probably	4 Unknown

24a. Wes en eutopsy

24b. Were autopsy findings evailable prior to completion of cause of deeth?

2 No


25. Wes case referred to medical	26. Plece of Death (Check only one)						
examiner? 1 ☐ Yes 2 No	Hospital: 1 npatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing H	Home 5 ☐ Residenca 6 ☐ Other			
27. Manner of Death  1 Anaturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred			

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, State)

☐ Residenca 6 ☐ Other (Specify)

1 IDCCertifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29a. Certifier

29b. Signet	yne end title of	certifier
	1	Mar
	lalue	10000

RESIDENT

29c. License number

200.0

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

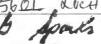
2004

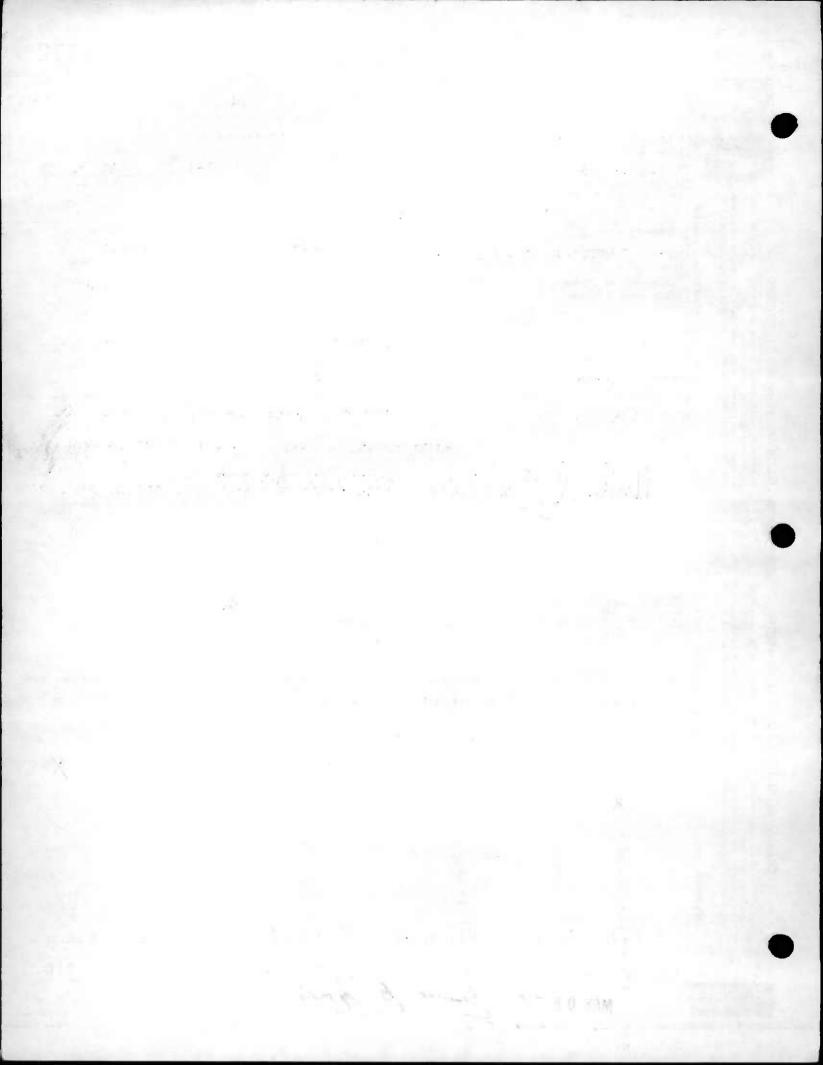
LUCH RAVENBUD. BALTIMORE SAMARITAN 5601 GOOD HOSPITAL 31. Dete filed (Month, Day, Year)

State Registrar

MAY 0 8 2000

32. Registrar's Signature





### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Gilbert F. Kain Jr. 1:42 p.m. 3, May 2000 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson If Under 1 Year tf Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 11-10-1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Year) 1XM 2□ F Months Deys Yrs. 213-20-8439 74 Baltimore, Md. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Md. Baltimore City 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21206 3706 Hamilton Avenue United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Yeer or Detes: WW II 14. Rece - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Auto Mechanic Ford Dealership 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Laura Lenora Mullen Gilbert F. Kain Sr. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 3807 Houcks Road Monkton, Maryland 21111 (Son) Michael McCarty 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from Stete 5/8/00 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Milton J Knight Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) month Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en autopsy 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) + 0 Spice 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be axecuted of Vital Records, Attending Physician: Division To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the

Physician

/Medical

**Examiner** 

Director

Funeral

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Completed

**Funeral** 

Director

Rems 23s

filed within 72 hours after of Hygiena. other than "natural", or ite

pemit. Pages 1 end 2 should be filed within 72 hours aft Department of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or any injury or other treumatic event, the Medical Exeminant injury or other treumatic event, the Medical Exeminant

**Physician** /Medical

Examiner

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After

after death.

funeral director,

the

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

29e. Certifier

(Check only one)

29b. Signeture and little of certifier

Maryland

**DHMH 16 Rev 6/95** 

Registrar

6701 32. Registrar's Signeture

completed cause of death (Item 23e) (Type, Print)

N-Chales St. Balto and

1/2 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

2 Medicat Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

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MY 082000 James & force

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14674

			$C\epsilon$	ertificate of	Death		Reg. No.		, , , , ,
Physician /Medical	1. Decedent's Nama (First, Middla, Frances J.	Kistler				2. Data of De May 0	Day	Year	3. Tima of Death 10:25AM
Examiner	4a Facility Nama (If not institution, 8820 Walth		320		4b. City, Town, or Parkvil		h 4c. County Balti		
Funeral Director	285-18-4479	5. Sex 7. Aga 1 □ M 21X F	(In yrs. last birthda) 80 Yrs.	Months Days			orth (1920	9. Birthe Caur Ohi	placa (Stata or Foraign ntry) O
Maryland at show	Usual Residence of Decedant  10e. Stata 10b. County  Md. Baltim		10c. City, Town or L Parkville				12. 13	1	10d. Inside City Limits 1 ☐ Yas 2 ☐ No
with the Mar Sa or 28a-1 si Lbs notified	10e. Street end Number 8820 Walther	Blvd. #3320		10f. Zip Coda 21234			10g. Cifizan of V		ntry?
urs after death with the Marylen all, or Hems 23a or 28a-f show Earning must be notified at by Funeral Director	11. Merifal Status  1 ☐ Never Merried 2 ☐ Marrie	12. Was Decedant Ex Armed Forcas?	var in U,S. 13	Was Decedant of If Yas, specify Cut		Specify Yes or No rto Rican, atc.)		ce - Americ ck, Whita,	
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tal H doth	17. Fathar's Name (First, Middle, Li	17. Fathar's Name (First, Middle, Last)  John H. McGarry  18. Mothar's Name France						10)	
1 end 2 should Health end Men em 27 is marke ther traumatic	19a. Informant's Name/Ralationship (Type, Print)  Mrs. Kristine L. Bauer/Daughter  19b. Meiling Addrass (Street and Number or Ru 19002 Hunt Pass Ct.								Coda)
ant of At: If its y or o	20a. Mathod of Disposition  1 Burial 2 Cramation 3 4 Donation 5 Other (Spe		20b. Place of Disposition (Nama of camatary, cramatory or other placa) Hilltop Service Co.				20c. Location - Towson,		own, Stata
permit. F Departme Importan eny injur	21. Signature of Funeral Service Li	Luchen		Ruck 1050	ess of Fecility Towson F York Rd.	uneral H Towson.	ome, Inc Md. 212	04	
Physician /Medical Examiner pus up properties of the properties of	Immediate Ceuse (Finel disassa or condition rasulting in death)	b	ua to (or as a conse	equence of):	n Car	cenm	~	1 1 1 1 1 1	6 month
nding physicie use as the bur n/Medical	Sequantially list conditions, if any, leeding to immediate cause. Enter Undarlying Causa (Disease or Injury that initiated avants resulting in death) Last  Due to (or as e consequence of):  c.  Dua to (or as a consequence of):  d.								
es that the death igned by the etten be detached for u by Physician	Part II. Other significant condition	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					tobacco use co		to the cause of death?
The law requires the case has been signed page 2 should be completed by				The I			s an eutopsy ormed?	ev cc	Vara autopsy findings veilebla prior to omplation of cause f death?
certificate he rector, page	25. Was casa rafarred to medical						Yas 28 No	1	☐ Yes 2☐ No
ding Phys h. Atter this funeral di	axaminar?  1 Yas 2 No  27. Mannar of Deeth  1 Natural 5 Pending invastiga  3 Suicide 6 Could no determin	t be 280 Bloss of Injur	Year) 28b. Time Injury	of 28c. Inju	ther: 4 Nursing ury at ork? Yas 2 No	28d. Dascribe	idanca 6 Oth	rred	ify) ral Routa Number,
To the Hospital or Attenuability 24 hours after death of the Funerel Director: completely filled in by the Medical Certifical	29a. Cartifiar 1 Certifying	Physician: To the best of caminer: On the basis of e	my knowledge, dee			e, end due to the	ceuse(s) and me		
vithin 2 to the comple	29b. Signeture and title of certifiar	and mannar state	2	K	sa number 2039	6	29d. Date signe		Day, Year)
BU	30. Nama and addrass of person w Davis M. Hahn, N		Raven Blvd		imore, Md.	21239	•		
State Registrar	31. Data filed (Month, Day, Year)  MAY 0	32. Registrar		4 1					

ORIGINAL

## Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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an cal	1. Decedent's Ne	me (First, Middle	A (Ast)			Certificate of Death				Reg. No.				
			,,							2. Dete of Month		Dav	Yeer	3. Time of Death
	Betty	Jane Lu	acke							Ма	У	Day 05 :	2000	9:25 A.M.
ner	4a Fecility Name	(If not institution	, give street end nu	ım <i>ber)</i>				4b. City, To	wn, or Lo	cation of D	eeth	4c. County	of Death	
	Route 1 at Route 32							Lau	rel			How	ard	
	5. Social Security	Number	6. Sex	7. Age (In	yrs. lest birth		nder 1 Year			8. Dete of	Birth		9. Birtho	place (Stete or Foreign
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1	Usual Residence						1			APL.	307	1901	ATEC	ушта
ľ	10a. Stete	10b. County		100	. City, Town	or Location							1	IOd. Inside City Limits
	Md.	Howar	-A		Colum	hia								1 ☐ Yes 2 ☐ No
						7: 0:4:				10-				
10e. Street and Number					101	. Zip Code				10g. Citizen of What Country?				
9527 Quarry Bridge Court						20794	1			U.S.A.				
11. Maritel Status 12. Was Decedent Ever in U Armed Forces?				in U,S.	<ol> <li>13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica</li> </ol>				ecify Yes o Rican, etc.	y Yes or No- an, etc.) 14. Race - Amer Black, White				
	1 Never Ma	rried 2 Marr	ied 1 ☐ Yes If Yes, Gi	2 No		1 ☐ Yes 2 ☐ No Specify:				Specify:				
	3 Widowed	4 Divorced	Year or D	Detes:		1010	XX	openiy.			White			
15. Decedent's Education (Specify only highest grade completed)				16e.	Decedent's I	Usual Occu	pation	t of work	ina	16b. Kind of Business/Industry				
-	Elementary/Se		College (		-	(Give kind of work done during most of wo- life. DO NOT use retired)				Jikniy				
	Grade 1		College (	1-401 347	F	lorist	t.			Flower			r Sho	Shop
	17. Fether's Nem	e (First, Middle,	Last)					18. Mothe	er's Name	e (First, Mic		den Suman		
	Lorran	For clu						N/ -			la -			
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4	20a. Method of D		3 Nemovel from			Disposition , cremetory		ice)	M	lay 10		. Location -	City or 10	own, State
		5 Other (Sp			lverar	een Bi	irial	Park	1	2000	1	oanok	A. V-	irginia
	21. Signature of	Funeral Service	Licensee		rerar			ess of Fecili	ly	2000		Canca		rrginia
	60	S L				Dona	aldsor	r Fune	ral	Home,	P.A	١.		
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1	23a. Pert1. Ente shock, or h	ryne diseese, or eert failure. List	complications that only one cause on	ceused the each line.	death. Do n	ot enter the	mode of dy	ng, such es	cerdiac	or respirato	ry errest,			Approximate Interval Between
														Onset end Death
	Immediate Cause (Final													
disease or condition resulting in death)  e. Multiple injuries												7		
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	disease or condi	tion	θ			onsequence		25			-	4		
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14676 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Year LINKINS mA-4:00 AM 4 2000 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALTEMORE SINGI MOSPITAL OF BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year)
APRIL 28,1927 If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 9. Birthplece (Stete or Foreign Months Days 1 ☐ M 2 🖾 F 73 WASHINGTON, D.C. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No ANNE ARUNDEL **FERNDALE** 10f Zip Code 10g Citizen of What Country? 21061 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married 1 ☐ Yea 2 ☐ No Specify: If Yes, Give Year or Detes: Specify WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) OWN HOME

3 Widowed 4 □ Divorced 15. Decedent'a Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme)

RILEY **ESTELLE** JOHN PAGE

19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNE L. NOVELL- DAUGHTER 1034 14TH STREET, UNIT 1, SANTA MONICA, CA 90403

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 5/16/00 ARLINGTON NATIONAL CEM. ARLINGTON, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify)

22. Name and Address of Fecility SINGLETON FUNERAL HOME, PA. 1401234 ar

1 SECOND AVENUE, S.W., GLEN BURNIE, MD 21061 Q

23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Onset and Death ERMINAL PNEUMONIA MONTH

Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of)

-UNG CANCER Due to (or es e consequence of)

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

YEARS

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy tindings evaileble prior to completion of cause of death? 24e. Was en eutopsy performed?

1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred

1 Netural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

MAY 4, 2000 mo Cum/8 2401 WEST BELVAPERE AVENUE 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

BALTI-MOKE, MARKEND SIZIS HOMAS ANTHON UMBO, MO SINAI HOSPITAL OF BALTIMORE 32. Registrer's Signature 31. Dete filed (Month, Day, Year)

Registra DHMH 16 Rev 6/95

**ORIGINAL** 

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Maryland 21215-0020 KNOWN Baitimore, **Physician** 

Examiner

**Funeral** 

Director

23a or 28a-f ahow

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Peges 1 and 2 should be nant of Health end Mental int: If Item 27 is marked of

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Department of
Important: If Its
any injury or o

Physician /Medical

Examiner

Physician/Medical Examiner

Be Completed by

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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

MAY 0 8 2000

death

filed within 72 hours after

other traumatic event, the Medical Examiner must be notified at

Funeral

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Completed

/Medical

ANNE

10a. Stete

MARYLAND

11. Merital Status

5. Social Security Number

578-38-7397 Usuel Residence of Decedent

10e. Street and Number

135 OLEN DRIVE

10b. County

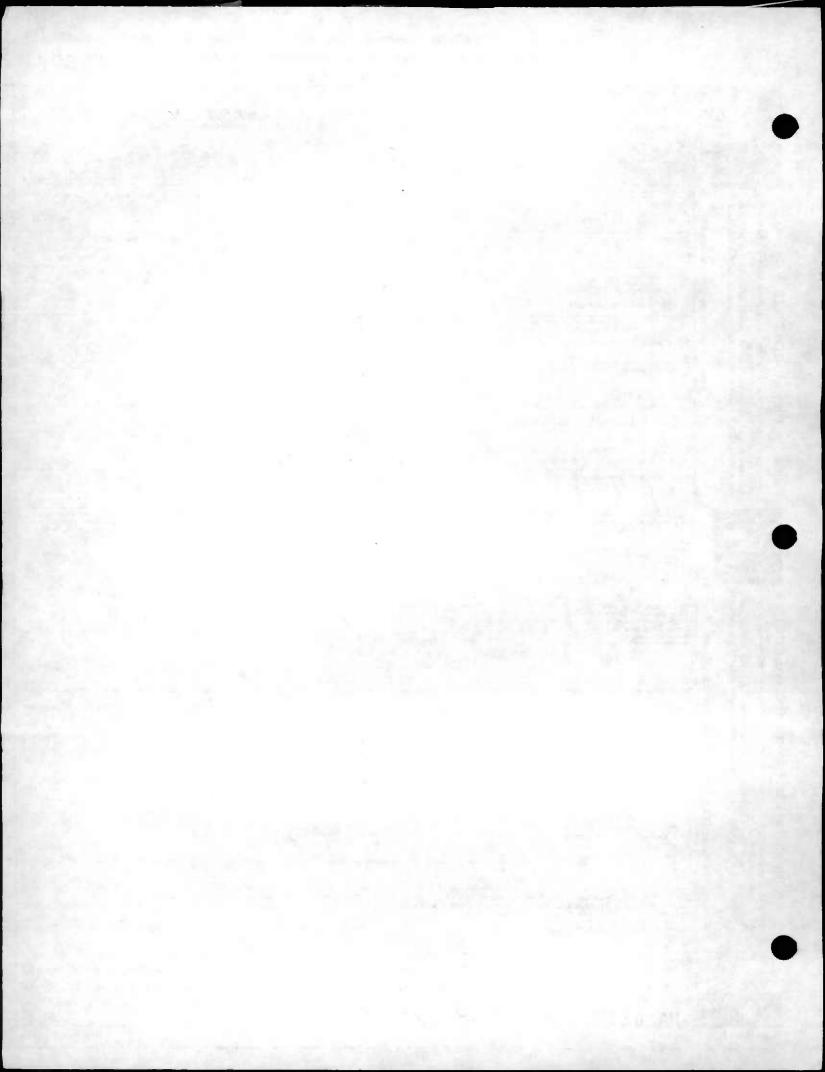
The law requires that the death certificate be executed Box 68760. P.O. of Vital Records,

Division

or Attending Physician: "after death.

Director: After this certifica Medical Certification: To the completaly filled in by To the Hospital of within 24 hours a To the Funeral D

State



## Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14677

Usual Residence of Decedent			C	ertificate of	Death	Reg. No		1707.1			
### Country of Less Process of Section of Section 19 (1997)   1997   199	Physician					Month De	ev Yeer	The second secon			
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18. Mother's Name (First, Middle, Mailten Surventee)   19. Maurice   1. Lessner   19. Maurice   1. Lessner   19. Mailten Address (Street and Number or Reut Protect Cape or Town, State, Ze Code)	1 0	11. Meritel Status 12. Wes Decede	onf Ever in U.S.	3. Was Decedent of H	ispenic Origin? (Specify	Yes or No-					
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1   During 2   Coremetion 3   Removal from State   Dulancy Valley Mem. Gardens May 9, 2000 Timonium, Md. 4   Donation 5   County of Part   Control	other 2		20b. Piece of Di	sposition (Name of				own, Stete			
11605 Reinterstown Rd. Orings Mills. Md. 21117   23a. Part   Show find disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest.   Approximate interval Between Onset and Death   Check on the statistical property of the	-					May 9,20	00 Timon	ium, Md.			
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Immediate Cause (Final desease or conditions desease or conditio		shock, or heart failure. List only one ceuse on eech	n line.					Intervel between			
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Sequentially list conditions, and leading to immediate cause. Either Underlying to the cause of course property and the cause of course of injury that initiated events resulting in death) Lest  Due to (or se a consequence of):  Due to (or se a con		disease or condition resulting in deeth) a. Herr	viation so	morrene							
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mo 12446 May 5,200	Med Med		e number								
	F 8	Service of the first of the service	10.0	017/11			May 5, 200				
30. Name and address of parameters of death (Item 23e) (Type, Print)  T Mattingly MD 22 South Grave St Bultimore, MD 2/2/10  State  31. Date filed (Motty, Day, Year)  32. egistrer's Signature				10/6	796	1 6	7				
State 31. Dete filed (Month, Dey, Yeer) 32 legistrer's Signeture	)	30. Name end eddress of parson who completed ceuse of	of deeth (Item 23e) (Ty	pe, Prinf)	MA AI	2212					
State 31. Dete filed (Month, Dey, Yeer) 32. registrer's Signeture			th Grane -	ST Baltimor	9 10 21	210					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** 6:12 A.M. 2000 Helen Rose Myers May ю /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner tranklin Square Hospital Center Rosadale Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 213 10 5903 1 □ M 2 1 F 81 Yrs. Director February 10, 1919 Maryland Usuel Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 22s or 28s-f show traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore **Essex** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 567 Compass Rd. 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritei Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yeer or Detes: White 1 Yes 2 No Specify: 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Seamstress 11 Clothing Mfg. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) permit. Pages 1 and 2 should be Department of Health and Mental Paul Thomas Hymiller Matilda Bowman Important: If Item 27 is m any injury or other traum once. 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Shirley Watkins (Daughter) 45 Right Wing Dr. Baltimore, Md. 21220 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 Donetion 5 Other (Specify) Holly Hill Mem. Gardens 5/9/2000 Baltimore, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 23a. Pah1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Myocardial Infarction 13 Hours Examiner Due to (or es e consequence of): Physician/Medical Examiner Acute Karal tailure attending physician and for use as the burlai-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Dependent Diabetes Mellitus Lasulin Records, P.O. Box 68760. Due to (or es e consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? i signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown þ cate has been sig., page 2 should b Completed 24b. Were eutopsy findings eveilable prior to 24a. Wes an eutopsy performed? completion of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; to 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 topatient 2 ER/Outpatient 3 DOA To 1 ☐ Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) Certification: 26b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Medical ( 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner steted. 29b. Signeture and title of certific 29c. License number 29d. Date signed (Month, Day, Year) May 6, 2000 RD 191783 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Baltimore, Maryland 21237 Kevin Brewster, 9000 Franklin Square Drive 31. Dete filed (Month, Day, Year) 32. Registrer's Agneture State

DHMH 16 Rev 6/95

Registrar

MAY 0 8 2000

WERS, Holen Rose

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** May 3, 2000 LeRoy Edgar Messick 12:15AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6 Honeycomb Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Dev. Year) Feb. 24, 1914 5. Social Security Number 7. Age (fn yrs. last birthday) **Funeral** Deys Months 1 AM 2 F 213-07-7368 Yrs. 86 Director Usual Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits -how must be notified at 1 ☐ Yes 2 No Director Middle River Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 6 Honeycomb Road United States death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Home 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status permit. Peges 1 end 2 should be filed within 72 hours after I Department of Heelth end Mental Hyglena. Important: If item 27 ie marked other than "naturel", or itel any injury or other treumatic event, the Medical Example 1 XYes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WWII þ 3€XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Steel Industry Crane Operater 9 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ivy B. Draper George J. Messick 2 19a. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21220 6 Honeycomb Road Middle River, Maryland Mrs. Alice I. Strathy 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Hilltop Service Corp. 5/6/2000 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility L. Yills Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final Renal all carrinone 4 years disease or condition resulting in death) Examiner Examiner physicien end the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medicai Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. P.O. t Yes 2 No 3 Probably 4 Unknown - phonorcy disease þ Records. 24b. Were eutopsy findings eveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital f or Attending Physician: after deeth. 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To this funaral 27. Menner of Deeth 1 2 Netural 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Division 5 Pending Investigation after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es steted.

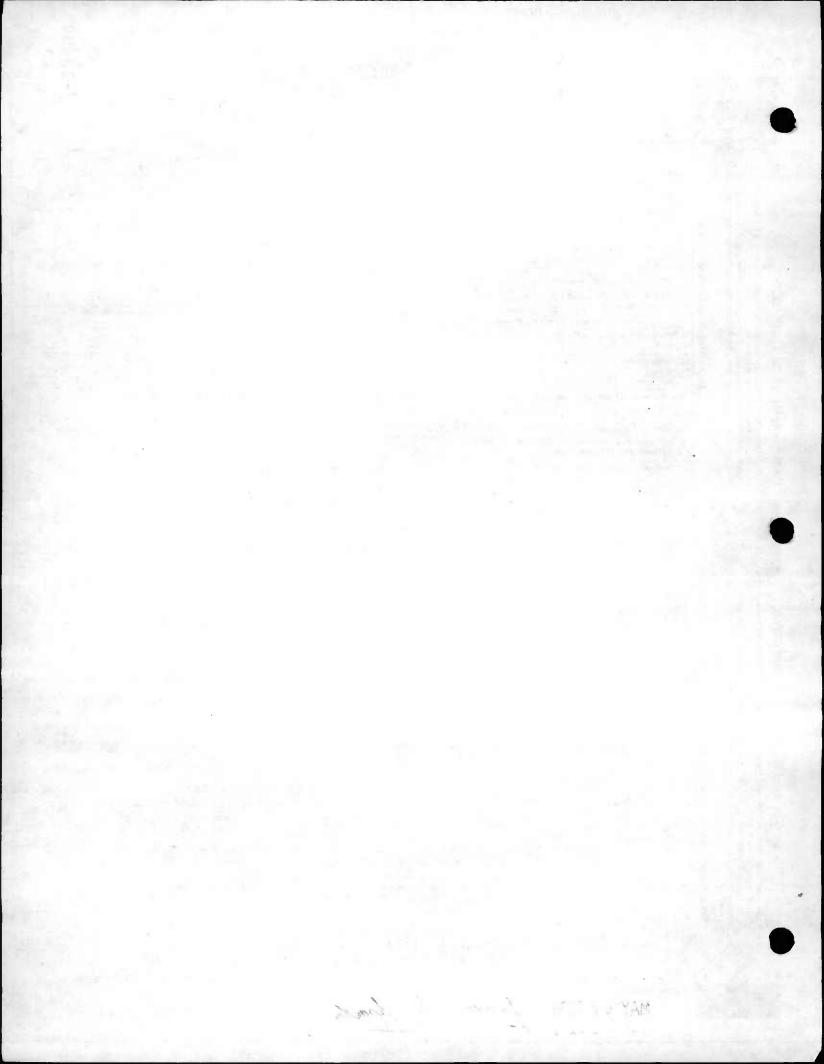
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier Mr. alle 2000 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Stoof R. W. 1185, MD 8114 Sent siger ard, set 212; Beld nine, MM 21236 32. Registrer's Signature 31. Date filed (Month, Dey, Year) State MAY 0 8 2000 Registrar

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Month Year 25 SOPHIA KOSMIDES **MEZARDASH** 5 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Carroll County General Hospital Carrol1 Westminster ff Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🖾 F Yrs. Turkey Director 217-56-4200 91 May 23, 1908 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Westminster Md. Carroll 10e. Street and Numbe 10g. Citizen of Whet Country? 21157 IISA 818 Winchester Dr Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien, permit. Pages 1 and 2 should be filled within 72 hours effer to Department of Health and Mentel Hygiene. Important if them 27 is marked other than "natural", or than any injury or other treumatic event, the Marine is a short and the first a Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own home 6 Home maker Saltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Kosmides Angeliki Matheopoulos Lazaros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gus Konstant/son in law 818 Winchester Dr. Westminster, Md. 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 5/9/00 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cemetery Woodlawn, Md. 21. Signature of Europeal Service Lice 22 Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that cause it is death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HEMORRHAGE INTRACEREBRAL Examiner Due to (or as a consequence of): Physician/Medical Examiner DISEASE YEARS PARTERIOSCLEROTIC VASCULAR anding physicien and use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Box 68760, that initiated events resulting in death) Last Due to (or es e consequence of) ettending | P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ete has been signed pege 2 should be de Records, 2 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physicien: '24 hours efter death.
 Funeral Director: After this carificalety filled in by the funeral director; p 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Ninpatient 2 ER/Outpatient 3 DOA 1 Yes 2 1 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 127 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil Medical 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) my DD 1663 DEEN 30. Name and address of purgop who completed cause of death (tiern 23a) (Type, Print) 906C WASHINGTON 20 INCENT Flocco Jr WESTMINSTER MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 0 8 2000 Registrar

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4681 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth MAY"2, 2000 LIBBY B. NEEDLE 10:05 PM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MANOR CARE ARDEN COURT BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) Deys Months Hours 1□ M 25 F Yrs. 577-10-0974 88 APR. 22, N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of Whet Country? 9608 CLEARVIEW PLACE 20901 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Yeer or Detes: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) BLACKER LEAH (UNKNOWN) 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MORTON NEEDLE / SON 11104 VALLEY HEIGHTS DRIVE - OWINGS MILLS, MD 21117 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) KING DAVID MEMORIAL PARK 5/4/00 FALLS CHURCH, VA 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death tmmediete Ceuse (Finel diseese or condition resulting in deeth) CONGESTIVE HEART FAILURE MONTHS Due to (or es e consequence of): ISCHEMIC CARDIOMYOPATHY YEARS Due to (or es e consequence of): CORONARY ARTERY DISEASE YEARS Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown MYELODYSPLASIA SYNDROME

**Physician** /Medical Examiner

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The law requires

Physician

/Medical

Examiner

10a. State

MD

10e. Street end Number

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**Funeral** 

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Pagas 1 and 2 should be filed within 72 hours aftar death nant of Health and Mental Hygiene.

7 is marked other traumatic event,

permit. Pagas 1 and 2 Department of Haalth a Important: If Item 27 is any injury or other tree

altimore, Maryland 21215-0020

Examiner Physician/Medical à

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Completed

24a. Wes en eutopsy performed?

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 Yes 2 No 26. Plece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

ASSISTED

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25. Wes cese referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier

MAY 0 8 2000

29c. License number D37573

29d. Date signed (Month, Dey, Year) MAY 3, 2000

30. Name end eddress of person propleted cause of deeth (Item 23a) (Type, Print)

JEFF ZIBELL, M.B 31. Dete filed (Month, Dey, Year)

7220 PARK HEIGHTS AVENUE 32. Registrer Signeture

BALTIMORE, MD 21208

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Year **Physician** 5: 10P Erma OGLE 3 2000 MAY /Medical 4a Facility Nama (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE CITY HOPKINS JOHNS 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 10 M 200 Days Yrs. 218-26-2065 70 Director MAY 5. 1929 MARYLAND Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits ahow 1 Yas 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be 607 OAKWOOD ROAD 21061 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 No Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after Hygiene. 1 ☑ Nevar Married 2 ☐ Married 21215-0020 1 ☐ Yas 2 No Specify: If Yas, Giva Year or Datas: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within 7. Department of Health end Mental Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic avent, the Mediana." Elementary/Secondary (0-12) College (1-4or 5+) MOTOR VEHICLES 12 SUPERVISOR ADMINISTRATION Saltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) 8 WALTER OGLE GLADYS DISNEY 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARGARET ROBERTA WEEKS (COUSIN) 225 QUAKER RIDGE ROAD, TIMONIUM, MD. 21093 Data MAY 6, 20a. Method of Disposition 20b. Place of Disposition (Nema of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State MEADOWRIDGE MEMORIAL PARK 2000 4 ☐ Donation 5 ☐ Other (Specify) ELKRIDGE, MARYLAND 21. Signature of Funeral Service Licen 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 40 try 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immedieta Causa (Final diseasa or condition rasulting in daath) /Medical MYOCARDIAL INFARCTION ACUTE ONE DAY Examiner Due to (or as e consequence of) Physician/Medical Examiner ARTERY DISEASE CORONARY YEARS attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown LUPUS ERYTHEMATUSUS page 2 should be det SYSTEMIC Records. by 24b. Were autopsy findings available prior to completion of cause of death? **Be Completed** 24a. Was en eutopsy RENAL INSUFFICIENCY performed? 2 X No 1 ☐ Yes 2 No 1 Yes certificate Division of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? director 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No edical Certification: To this funeral 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred After 1 Netural 5 Pending invastigation e Hospius. n 24 hours after deeth. he Funeral Director: Aft 1 Yas 2 No 2 Accident 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicida 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, data and place, end due to the cause(s) and manner steted. within 24 hou To the Funer completely fil 29a. Certifier ŝ 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) mfrowell MD Resident RES 000 May 3, 2000

State Registrar

T. PROWELL

31. Date filed (Month, Day, Year)

MAY 0 8 2000

**DHMH 16 Rev 6/95** 

HOSPITAL

600 NORTH WOUFE ST BALTIMORE 21287

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

JOHNS HOPKINS

32. Registrar's Signatura

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4683 Certificate of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Data of Deeth RENNICK 10:45AM 5 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BonSecour Hospital Baltimore NA If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days 1□ M 2□ F Months Hours 89 Yrs 05-10-10 NC 217-09-3597A 10b. County 10c. City, Town or Location 10d. Insida City Limits NA Baltimore Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 7103 Rudisill Court 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yas 24☐xNo If Yes, Give 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specity: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Driver's Aide NA Baltimore City Sch. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Day Wilkerson Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207Morgan Α. 3220 Mayfair Road Baltimore, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State MD. Dete XXBurial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. Cem. 05-08-2000 Randallstown, 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, Maryland 21202 WM. C. March FH 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enges two heart the cause of death? pably 4 Unknown

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page 2 certificate has

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, to

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The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Examine

Physician/Medical

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Medical Certification: To Be Completed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or hams 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or hame 28a any injury or other traumatic event. the

altimore, Maryland 21215-0020

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5. Social Security Number

10e. Street and Number

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William

20a, Method of Disposition

William

10a. State

Funeral Director

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Be Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting In death)

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ons contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to
	24a Was an autonsy 24b. We

Part II. Other significant condit Were eutopsy findings available prior to completion of causa of deeth? performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner es steted.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and title of certifier

29c, License number

29d. Date signed (Month, Day, Year)

ted cause of death (Item 23a) (Type, Print) 30. Nama and address of person who comple

W. MOUNT Royal Ave, Baltimore 21217

State Registrar

31. Date filed (Month, Day, Year)

MAY 0 8 2000

MY 0 8 2000 - Secretary of Secretary :

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14684 Certificate of Death 1. Decedent's Name (First, Middle 1 ast) 2. Date of Death 3. Time of Death Month Physician 6, May 2000 8:45 AM WILLIAM ALBERT POMLES /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore Hospice of Baltimore, Gilchrist Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 26, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Hours YES 217-24-3384 Md. Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mantal Hygiene. Importants if item 27 is marked other than "natural", or itema 23a or any injury or other treumatic avent, the Medical Examines must be a 212 Upnor Rd. 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 12/Yes 2 1 No if Yes, Give Year or Dates: Korea Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Narried 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Korea White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Regional Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Car1 Pomles Katherine Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dolores Pomles/wife 212 Upnor Rd. Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cornetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 5/8/00 Towson, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 18 month Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician end d for use es the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initieted events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by pege 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 K No certificate in or Attending Physicien: The star death.

In Director: After this certificated in by the funeral director, pe 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) of 05 pice Certification: To 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signeture and titlefol certific 29d. Date signed (Month, Day, Year) uns

Julian Pombe

The law requires that the death certificate be axecuted

Division of Vitai

31. Date filed (Month, Day, Year) MAY Registrar

0 8

d cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

16

St. Balto md 21208

which is a series of the

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day C. Phelan Jerome May 4, 2000 3:45 AM 4a Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Holly Hill Manor Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) May 18, 1905 6. Sax Birthplaca (State or Foreign Country) MD 7. Aga (In yrs. last birthday) Days **X**M 2□ F 94 Yrs. 215-10-2372 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 Yas 2/00No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 B Epsom Road 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 270No If Yas, Giva Yeer or Datas: 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Nevar Merried 2 Married 1 Yes XXNo Specify: Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Letter Carrier US Government 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Daniel J. Phelan Mary C. Suehle 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Md 21286 Jerome C. Phelan Jr. / Son 510 Epsom Road Towson 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Nother (Specify) Entombent 5/10/2000 Moreland Balto. 21. Signatura of Funaral Sarvice Licensee Matthew T. Canapp 22. Name and Addrass of Facility Leonard J.Ruck, INC. Matthew T. Canapp Leonard J.Ru 5305 Harford Road 23a. Pert1. Enter the diseasa, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart tailure. List only one cause on each line. Balto.Md 21214 Approximete Intarval Between Onset and Death Immediata Causa (Final disaasa or condition resulting in daath) · ARTERIOSCLEROTIC CARDIOUASCULAR YEMRS Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or es e consequence of): that initiated evants resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an eutopsy

1 Yas

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only ona)

2 00

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

04 MAY 2000

24b. Were eutopsy findings evailable prior to

completion of cause of death?

1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Completed

Be

r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after Hygiena.

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: if Item 27 la marked other than "na any Injury or other traummite event, the Media page.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed by Be

25. Was casa refarred to medical

1 Yas 2N No

27. Mannar of Death

1 Natural

2 Accidant

4 Homicida

(Check only one)

29b. Signature and title of contifier

3 Suicida

29a. Cartifiar

anding physician and use as the bunal-transit Certification: To Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlansit Box 68760. P.O. Records, Division of Vital

**DHMH 16 Rev 6/95** 

Registrar

T Leavey MD. 31. Data filed (Month, Dey, Yaar) MAY 0 8 2000

30. Nama and addrass of parson who complated causa of deeth (Item 23a) (Type, Print)

5 Panding invastigation

6 Could not be detarmined

32. Registrar's Signatura

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28e. Data of Injury (Month, Day Year)

1205 York Road. Ste 38. Lutherville MD 21093

🔂 Certifying Physician: To tha best of my knowledge, death occurred et the time, data and place, and dua to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner stated.

29c. License number

9-17641

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

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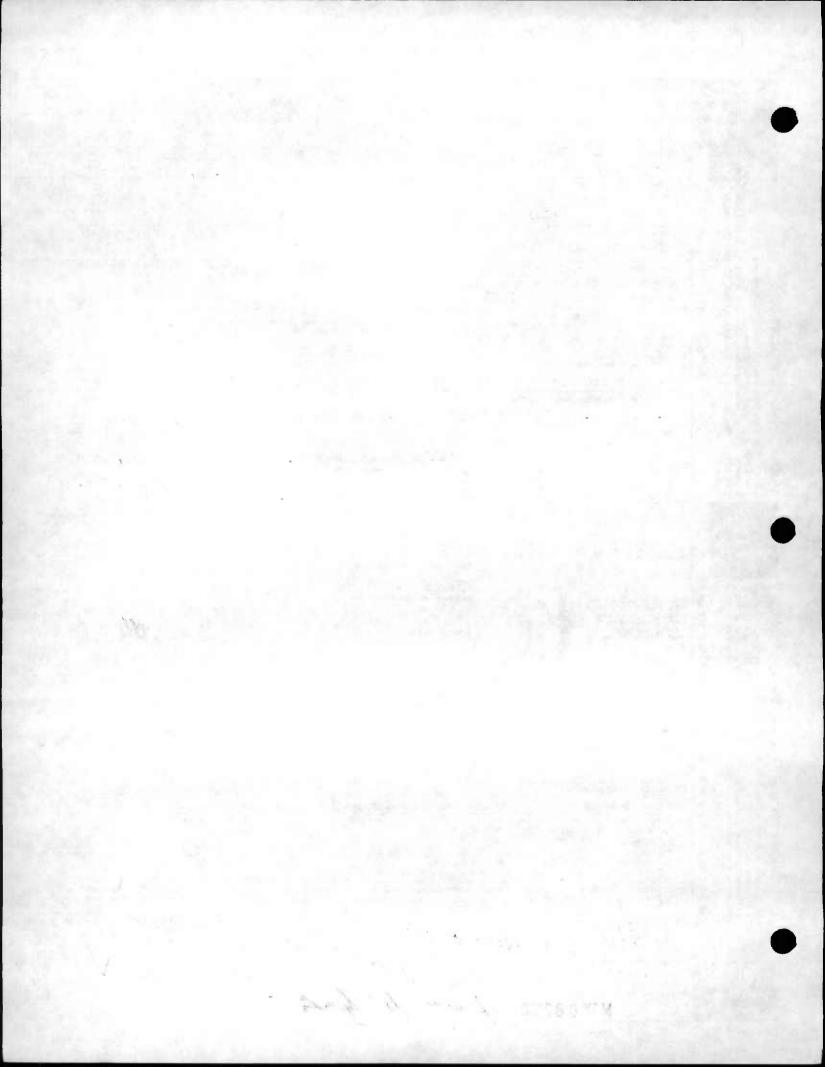
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## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Certificate of		Reg. No.	14686
	Dhusisian	Decedept's Name (First, Middla, Last)	2. Date of De	Day Year	3. Tima of Death
	Physician /Medical	EVELYN	TEKPS APRI	(30 2000	22:20
	Examiner	4a Facility Name (If not institution, give street and number)	4b City, Town, or Location of Deat	th 4c. County of Death	h
		VOLAS TIGHETUS DAYUEW MEXICAL (ENTEX	DALTIMORE		
	Funeral Director	5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year 214-72-1397 1 M 2 1 F 44 Yrs.			hplaca (Stata or Foraign untry) ryland
	Du Maria	Usuel Rasidence of Decedent  10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits
1	4 sho	Manage 2 2	Dundalk		1 ☐ Yes 2 🖾 No
4	inter deem with the ma rithern 23a or 28a-1s inter rount be notified Funeral Director	10e. Street and Number 10f. Zip Coda	Patradix	10g. Citizan of What Co	ountry?
100	38.0	8054 Gray Haven Road	21222	United S	tates
0	me 2	11. Mental Status 12. Was Decedent Evar in U,S. 13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Specify Yas or Noban, Maxican, Puerto Rican, atc.)	o- 14. Race - Ama	
21215-0020	by Fr.	1 Nevar Married 2 Married 1 Yas 2 No If Yes, Give 1 Yas 2 No If Yes, Give 1 Yas 2 No		Specify:	hite
5-0	"natural", olea En	15. Decedant's Educetion (Specify only highast grade completed) 16a. Decedent's Usual Occu (Giva kind of work don lifa. DO NOT usa retin	ipation	16b. Kind of Business/I	
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2	Hygler the Co.	12 Years Security O		Electric Co	ompany
5 3	Sec S	17. Fathar's Nama (First, Middle, Last)  Leo Ferrerri	18. Mothar's Nama (First, Middle		
2	snould and Men america urmatica		Virginia (Not of and Numbar or Rural Routa Numb		Zin Code)
N S	475	Mr. Jimmy C. Phelps (Husband) 8054 Gray H			111 - 111
	or other tr	20a. Method of Disposition 20b. Place of Disposition (Nama of	Data	11k, Marylan	
Baltimore,	nages net of l int: If its iny or o	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)  Hillton Service		Фетте	
	: 문문증	21 Signature of Funeral Service Licensee 22 Name and Addr	ass of Facility	Towson,	
Ö	Depa eny le		k Funeral Home o		Inc.
		23a. Part1. Enter the durlase, or complications that ceused tha daath. Do not entar tha moda of dy shock, or heart failure. List only one ceuse on each line.	se Ave. Dundalk,	Maryland arrest,	21222 Approximete
P	hysician	snock, or haart traine. List only one cause on each line.			Intervel Batween Onsat and Death
Ale I	/Medical	Immediate Cause (Finel disaasa or condition ) UBARAC hulo to Hardington	MORLHAGE		
E	Examiner	resulting In deeth)  Due to (or es a consequence of):	MURATAGE		
7	e = E				
	incate be executed to physician end as the buriel-transit	Sequentially list conditions,  Dua to (or as a consequence of):			
68760,	cian cian	Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Causa (Diseasa or Injury that initiated events  Dua to (or as a consequence of):			
87	physicia s the bur edical	that initiated events rasulting in death) Last Dua to (or as a consequence of):			
	ding	d			
Вох	met the deem cented by the attending detached for use yellow by Physician/N				
P.O.	y the iched	Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse g	1 4	tobacco use contribute	
<b>D</b>	dete y	MYPELTENSION, STROKE, BELATERAL	(ALOLE)	Yee 20 No 3 Pr	robably 4 Unknown
of Vital Records,	The law requires that the deem centrale hes been signed by the attending page 2 should be detached for use a Completed by Physician/M	CE			Wara autopsy findings
0	shoe	STENOSES	part		availabla prior to complation of ceusa of daath?
Re 3	rine law sata hes b page 2 s		10		1 □ Yes 2 □ No
E E	certificata hes rector, page 2	25. Was cese rafarred to medical	26. Placa of Death (Check only		12.00
5	this certific rel director,	everniner?	thar: 4 Nursing Homa 5 Res		cifv)
0	ar this serei di	27. Mannar of Death 28a. Data of thjury 28b. Tima of 28c. Injury		how injury occurred	
0	r deeth. ector: After by the fune	2 Accident investigation M 10	Yas 2 □ No		
	after deeth. Director: After I in by the fune	3 ☐ Suicida 4 ☐ Homicide  6 ☐ Could not be determined  28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)		(Streat and Number or Rubwn, Stete)	ural Routa Number,
	tal of Attending Prince and Director: After the led in by the funerance Certification:				
	Fune Fune Stehy fill	29a. Cartifiar (Check only one)  2 Medical Examiner: On the basis of examinetion and/or invastigation, in my and menner stated.	ime, date end place, and dua to the opinion, daath occurred at tha tima.	ceuse(s) end mannar as , date and place, and dua	s statad. a to tha causa(s)
100	Me thin within		nsa number	29d. Data signed (Monti	h, Day, Year)
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		30. Name and addrass of person who complated causa of depath (Itam 23a) (Type, Print)	77 1	7///	111
6	B	( hastopher 5. Williams m) 4940kg	3 tens HVENUR B	alteriore, !	14/1/AND 21224
	State	31. Data filled (Month, Day, Year) 32. Register's Signatura		/	1
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

					(	Certi	ificat	e of	Death			Reg. No.	00	1468
Physician	1. Decedent's Neme (First, M				11	DM	BEZ	<b>y</b>			2. Dete of Dec	Dey	Yeer	3. Time of Dee
/Medical	4a Facility Neme (If not instit			umber)	,	10,	501	•	4b. City, To	wn, or L	MAY ocation of Deeth	04 4c. C	County of Death	
Examiner	GOOD SAI	TAL						HORE.		N/A	24			
Funeral Director	5. Sociel Security Number 213-38-1066		x □M 2½0 F	7. Age (In y	rs. last birth	July/	If Under Months	1 Year Deys		24 Hrs. Min.	8. Dete of Bird (Month, De July 8	y, Yeer)	Co	npleca (Stete or Foi untry) 7 Land
acel Examiner must be notified at steed by Funeral Director	Usuel Residenca of Deceden  10a. State 10b. Cou			10c.	City, Town	or Loca	ation							10d. Inside City Lie
, or items 23a or 28a-f show aminer must be notified at y Funeral Director										1 ☐ Yes 2 ₹				
be notified Director	10e. Street end Number						10f. Zip	Code				10g. Citize	en of Whet Co	untry?
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bet	15. Dece (Specify only hi	dent's Edu	ucation	n	16a. [	Deceder	nt's Usue	ol Occu	petion	t of work	cina	16b. Kind	d of Business/l	ndustry
Completed	Elementery/Secondary (0-1			/ (1-4or 5+)					during mos	or worr	ang .			
	17. Father's Name (First, Mid	dlo I est)			НО	mema	aker		18 Moth	ar's Nam	e (First, Middle,		Home	
o Be	Robert Tayı									Rosa			amamey	
To	19a. Informent's Name/Relet		ype, Print)		19b.	Meiling	Address	(Stree			re/Route Numbe		Town, Stete, Z	ip Code)
	Mrs. Evelyn Ha	ardes	ty/Dau	ghter	91	2 S	tarb	it :	Road	Tow	son, Mai	glan	d 2128	5
	20e. Method of Disposition  1  Burial 2  Cremati 4  Donetion 5  Othe			Stete	Place of I cemetery	, creme	tory or o	ther ple		5	Dete /6/00		ation - City or imore,	Fown, State Maryland
	21. Signature of Funeral Sen	rice Licens	10	21					ess of Facili	R	uck Tows			Home, In
/Medical Examiner	disease or condition resulting in deeth)  Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest	{	b	Due to	o (or es e co	onseque	enca of):	cce	DENT					7 DAYS
Physician/	Pert II. Other significant con-	ditions co	ntributing to d	death but not i	resulting in	the und	lerlying c	ause gi	iven in Pert	1.			/	to the cause of de
Completed by										Tug Marie Ma Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Ma Marie Ma Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Ma Ma Marie Marie Marie Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	24e. Wes	en eutops med?	a	Vere eutopsy findin vaileble prior to completion of cause
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	27. Menner of Deeth 1 ☑ Neturel 5 ☐ Per 2 ☐ Accident inv	nding estigetion	_	of Injury onth, Dey Year,				Bc. Inju			28d. Describe			,
Certification:	3 Suicide 6 Co	uld not be ermined	28e. Plac build	e of Injury - A ling, etc. (Spe	t home, fem	n, stree	t, factory	, office			28f. Location (: City or Tox		Number or Ru	rei Route Number,
edical 0	29a. Certifier 12 Certifier (Check only one) Medi	fying Phys cal Exami	iner: On the b	e best of my k pasis of exam- nner steted.	knowledge, inetion end	deeth o	occurred stigetion	et the t , in my	ime, dete er opinion, dea	nd pleca. ath occur	end due to the red et the time,	ceuse(s) e date end p	end menner es placa, end due	steted. to the cause(s)
Me	29b. Signeture and title of car	tifier	ha		de.	'n			se number	2			signed (Month	2000 °
	30. Name and address of per- ANUT K - MA	son who co		ise of death (I			rint)	4	dest,	B	ALTIMO	RE,	Mo	
State	31. Date filed (Month, Day, Yo		-	Registrar's Sig	-	,	,	,	5.00					
istrar	MAY 0	8 200	30	Beper	~ /	9	1	MA	5					

DHMH 16 Rev 6/95

Keen 'n Ann

ORIGINAL

State

Registrar

Stephen 5: 31. Dete filed (Month, Day, Year)

MAY 0 8 2000

Radentz

32. Redistrer's Signeture

111 Penn Street, Baltimore, Maryland 21201

MAY 0 8 2000 June 1. July

	ر المالية		Certificate of Death		Reg. No.		
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xaminer	48 Facility Nema (If not institution, giva s			or Location of Daath	4c. County of	Death	
	UNIVERSITY OF MARY					14	
neral	5. Social Security Number 6. Sex	M 2 F 7. Aga (In yrst la:	st birthday) If Undar 1 Yaar If Undar 24 H  Yrs. Months Days Hours M		y Year)	9. Birthplace (St Country)	ata or Foraign
	Usual Rasidence of Decedent	74	0	Hugust	x 1953	1,	(0
	10e. Stata 10b. County	10c. City,	Town or Location,			10d. Insid	da City Limits
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natures, or sense 23s of 23s-7 enow edical Examiner russ be notified at letted by Funeral Director	10e. Street and Number		10f. Zip Coda		10g. Cijizan of Wi	nat Country?	
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je je	11. Maritei Status	12. Wes Decedent Evar in U.S. Armed Forcas?	. 13. Was Decedant of Hispanic Origin? If Yas, specify Cuban, Maxican, Pu	Specify Yas or No-	14. Race	- American Indie	n,
를교	1 Navar Married 2 Married	1 Yas 2 No	1 Yas 2 No Specify:	ano nican, atc.)		Whita, atc.	N
1 by	3 ☐ Widowed 4 ☐ Divorced	Yaar or Datas:	TE Tas 20 No Specify.		Specify:	OBYTHEK!	can
Be Completed	15. Decedent's Educ (Specify only highast grada	cation complated)	16a. Decedent's Usual Occupation (Giva kind of work dona during most of w lifa. DO NOT usa retired)	vorking	16b. Kind of Busi	inass/Industry	
igh	Elemantary/Secondary (0-12)	College (1-4or 5+)	lifa. DO NOT usa retired)				
S	2711	6	Courview				
B	17. Father's Name (First, Middla, Last)	iha	18. Mothar's N	lama (First, Middla,	Maloan Sumama,		
2	MW 19.00	ruser		10,	you w		
	19a. Informant's Name/Relationship (Tyr	De, Print)	19b. Mailing Addrass (Streat and Number or	Tull f	or lown, s	tara, Zip Coda)	1121
A	20a/ Malhod of Disposition	20h Pla	ce of Disposition (Nama of	Data	20c. Location - C	ity or Town Sta	1201
	Un Buriai 2 □ Cramelion 3 □Ra	0 000	matary, cramatory or other place)	Flata	Bank		
	4/□ Donation 5 □ Other (Spacify)	uri	auco Mem. Fame	0/9/00	Valle	nove,	40
once.  To Be Completed by	21. Signatura of Funaral Sarvice License	20/1/	22. Nama and Addrass of Fecility	10. Ho	ne) K	4	
	Mounday 1	Mole	638 Ni Sili	nor St.	Ealt	nore ke	102121
	23a. Part1. Entar tha disaasa, or complice shock, or haart tailura. List only on	cations that caused tha death. a causa on each line.	Do not antar tha moda of dying, such as cerd	liac or raspiratory er	rast,	Approx	I Batwaan
an						Onset	and Death
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Completed by Physician	ourse arginicant conditions cont	allooting to death but not rasult	ing in tha undarlying causa givan in Part I.	1		noute to the ca 3 ☐ Probably	
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E				- 100	Xt		o Class
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o Be	examiner?	ospitel: 1 Inpatiant 2 El	Othar:	Daath (Check only only only only only only only only		(C-0.0/h.)	
. To	27. Mannar of Death	1	P/Outpatient 3 DOA Warsing  28b. Tima of Injury Work?		now injury occurre		
to	1 Natural 5 Panding invastigation	(Month, Day Year)	Injury Work?  M 1 Yas 2 No				
1ca	3 Suicida 6 Could not be	28a. Place of Injury - At hom	na, farm, street, factory, office		Street and Number	r or Rural Routa	Number,
Certification:	4 Homicida	building, atc. (Specify)		City or Tov	vn, Stata)		
	29a. Cartifiar 1 Certifying Physi	cian: To the best of my knowl	edga, daath occurred at tha tima, data and pla	ice, and dua to tha	ceusa(s) and man	nar as stated.	
edical	(Check only 2 Medical Examin	er: On the basis of axamination and mannar stated.	on and/or invastigation, in my opinion, daath or	ccurrad at tha tima,	data and place, ar	nd dua to tha car	usa(s)
Medical Certification:	29b. Signeture and titla of certifiar		29c. Licansa number		29d. Data signed	(Month, Dey, Ye	nar)
1	Allen A	20 110	212113		5/4/00		
1	30. Nama end addrass of person who cor	molated cause of death (Item 5	P12413		2/4/00		
40	22 S. GREENS ST						
Chah	31. Data filed (Month, Day, Year)	32. Ragistrar's Signatu					
State	o Data mod (Month, Day, 1881)	JE. Haylandi's Signatu					

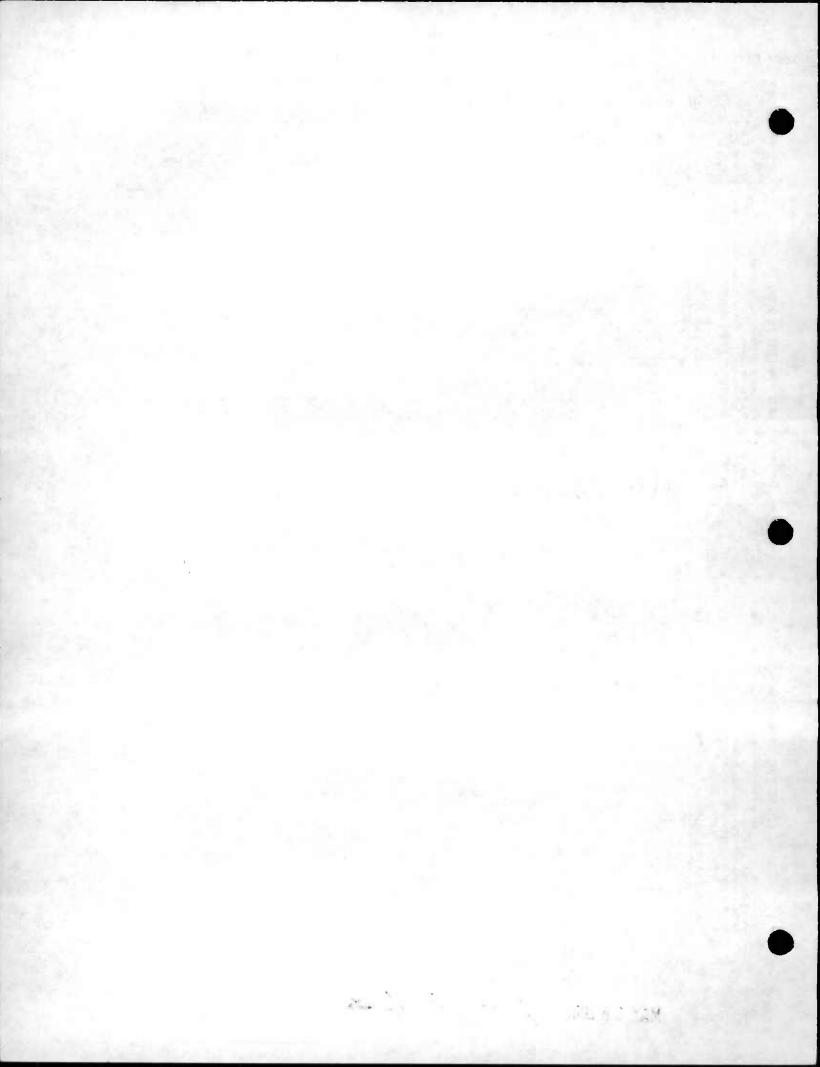
**DHMH 16 Rev 6/95** 

State Registrar 00-2374-510 crn Harry Stokes

## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14690

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sician	1. Decedant's Name Harry	a (First, Middla, Li A .		es				2	Month	Day	Yaar	3. Tima of Death
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miner										4c. County		
			rd Street			If Undar 1 Yaar		imore			N/	
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runeral Director	MD	NA		Bal	timo	re						X-X ·us z = ····
	10e. Street and Nun					10f. Zip Code				10g. Citizan of	What Cou	ntry?
,	2438 N	. Howar	d Street			212	18			USA		
ľ	11. Marital Status		12. Was Decedent Armed Forcas?	Ever in U,S.	13. W	as Dacedant of Yas, specify Cut	Hispanic Orig	gin? (Spaci	fy Yas or No-	14. Ra	ce - Amari ck, Whita,	cen Indian,
Į	1 Navar Marrie	ed 2 Married	X X Yas 2□			□ Yas 21 No		, , , , , , , , , , , , , , , , , , , ,	oon, ato.,			
l	3 D Widowad	4 Divorced	If Yes, Give Yaar or Dates:		'	⊔ fas ZALINO	Specify:			Specif	y: Bla	ick
		15. Decedent's E	ducation	1	6a. Decede	nt's Usual Occu	pation			16b. Kind of B	usinass/in	dustry
ŀ	(Space Elementary/Second	ify only highast gr	rada complatad)  Collega (1-4or	5.1	(Giva k	ind of work done O NOT use retire	i during most ed)	of working				
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ı		5 Other (Speci		Gar	rison	n Fores	st VA	Cem.	. 05-0	08-200	O Ow	ings Mil
Ì	21. Signatura of Fu	naral Sarvice Lice	ensaa /		22.	Nama and Addr	ass of Facility	y Ba	altimo	ore, M	arvl	and 2120
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dicai	Sequantially list cor if any, laading to im causa. Entar Unda Cause (Disaase or that initiated events rasulting in death) L	rtying injury .ast	c	Dua to (or as	a consequ	ance of):			-			
n/Medical			d									
-	Part II. Other signifi	cant conditions	contributing to death b	out not rasultin	ng in tha un	darlying ceusa o	ivan in Part I.		23b. Did t	obacco usa co	ontributs t	o the cause of death
						, , , , , , ,				Yes 2 No	-	bably 4 Unknow
										20,110	,	
									24a. Was	an autopsy	24b. W	ara autopsy findings
									parto	rmed?	CC	vailabla prior to emplation of causa
									part	ial	ot	death?
									120	ras 2□ No	12	Ø∜as 2□ No
	25. Was cese referr	ed to medical						of Death (	Chack only o	ne)		
	1 Yas 2□	No	Hospital: 1   Inpati	ant 2 ER	/Outpatient	3□ DOA O	thar: 4 Nu	rsing Home	5 ☐ Rasio	dance 6 10tl	nar (Spaci	Back yar
	27. Manner of Death 1 ☑ Netural 2 ☐ Accidant	5 Pending	28a. Data of Inju (Month, Da	iry Year) 28	b. Tima of Injury	M 1	ury at ork? ☐ Yes 2 ☐ I		d. Dascribe t	now injury occu	rred	,
	3 ☐ Suicida 4 ☐ Homicida	6 Could not to determined	Zoa. Place of in	jury - At homa ic. (Specify)	a, farm, stra	at, factory, office		28	f. Location (S City or Tox		ber or Run	al Routa Number,
	29a. Cartifier (Check only		hysician: To tha best miner: On tha basis o									
modical columbation:	one)	-X	and mannar st									
	29b. Signatura and	titla of certifiar	0 0 0			29c. Licar	nsa number			29d. Data signa		
	Non	mi	Chart.	40			O.C.M	.E.		April 3	30, 20	000
	30. Nama and addre	ss of person who	complated causa of	daath (Item 23	Ba) (Type, F	rint)						170,000
	Delas	- J.C	hi. Lan			11 Penn	Stree	t Ra	ltimor	n Mars	rland	21201
	31. Data filed (Mont	h Day Veed	32 Project	rar's Signatura		TT TCHI	Derec	c, Da	тещиот	C, Flaty	LUIU	Z1201
e ar	MAY A		Benetic	19	10	alla						



4c. County of Deeth

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Patr	ricia Shor AMEND ITE	ter MS: #23 PART I, I	State of Maryland / De	epartment of Health and Me Centificate of Death	ntal Hygiene 00	1469
	Physician	Decedent's Name (First, Middle, Les Patricia	Shorter	2	Dete of Deeth Month Dey Year	3. Time of Deeth
	/Medical	a Fecility Neme (If not institution, give		4b. City, Town, or Loca	May 02, 2000 tion of Deeth 4c. County of Deeth	10:20 A

Pat		cia MENI	Sho
		Physic /Med Exam	ical
		unera irectoi	
-0020	2 hours after deeth with the Meryland	stural, or items 23a or 28a-f show	ted by Funeral Director

4a Fecility Neme (If not institution, give street end number)

Baltimore, Maryland 21215

To the Hospital or Attanding Physician: The lew requires that the death certificate be axecuted within 24 hours affer deeth.

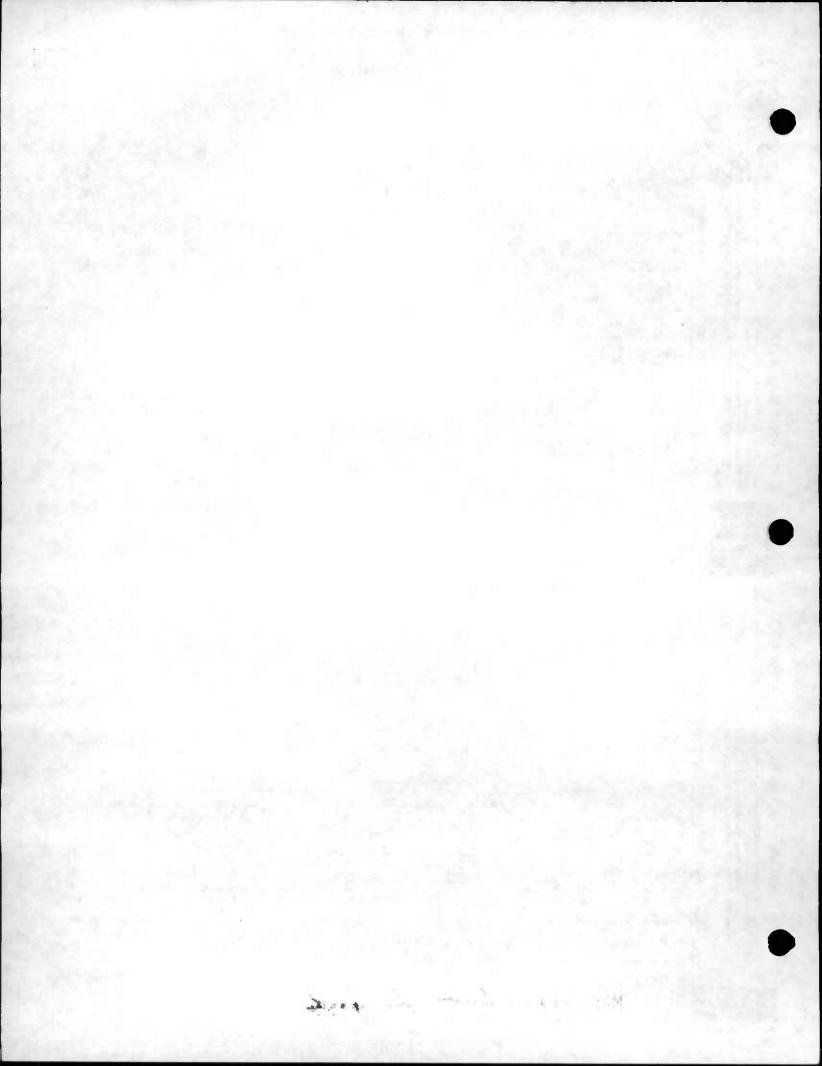
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the huntilatrancial Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

2.5 Scored Scarchy Number 2.13 = Good - 74 2.6 = Care 2.13 = Good - 74 2.6 = Care 2.13 = Good - 74 2.6 = Care 3.5 Score Scarchy Number 3.5 Score S	Johns Hopkins	Hospital				Balti	more	N	/A
106. Street and Number   106. Country   107. Street and Number   107. Street   107. S	5. Sociel Security Number	6. Sex				r If Under 24 Hrs	8. Date of Birl (Month, Da	h y, Year) -50	Birthplece (Stete or Foreign Country)     M D
MD									
100. Zip Code   120. Zip Cod	Oa. State 10b. County								10d. Inside City Limits
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15   December   Specifical   15   December	X1X Never Married 2 ☐ Merr	ied 1 ☐ Yes	2 No						
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Del1 Shorter    Informed Shorter   Italy				INCD	cuarant	18 Mother's Na	me /First Middle		
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A commence of the process of the p				19b. Mai	iling Address (Stree	et and Number or A	ural Route Numbe	er, City or Town,	State, Zip Code)2 1 20 2
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Voshell Mem. Gardens 05-09+2000 Dundalk, MD.  Signature of Funeral Service Licensee  22. Name and Address of Facility Baltimore, Maryland 2126  WM.C. March FH 1101 E. North Avenue  38. Part. Enter the disease, re-comptisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate intervel Between Conset Indiana Service Classes (Final seese or conditions sufficient and the Cause (Final seese or conditions)  Busing in death) Last  Due to (or as a consequence of):  23b. Did tobacco use contribute to the cause of respiratory arrest.  The Conditions contributed to the cause of respiratory arrest.  Was case referred to medical examinary  No. Hospitel:   Impatient   2/XER/Outpatient   3  DOA   Doker   4  Dursing Home   5  Residence   6  Other (Specify)    24b. Were an adopty in the cause of respiratory arrest   1  Ves   2  No   3  Probably   2  University   2  No   3  Probably   2  No   2  No   3  Probably   2  No   3  Probably   2  No   3  Probably   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   2  No   3  Probably   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   3  No   4  Other   4  Dursing Home   5  Residence   6  Other (Specify)   5  No   5	e. Method of Disposition		20b. P	lace of Disp	position (Name of		Date	20c. Location -	City or Town, Stete
22. Name end Address of Fecility Baltimore, Maryland 2120 WM.C. March FH 1101 E. North Avenue  Approximate seeds to condition as the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  ACUTE NARCOTIC INTOXICATION  Due to (or as a consequence of):  Due to (or as	1 Buriel 2 Cremetion						05 00		
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Completion of cau of deeth?  Was case reterred to medical examiner?    May 03, 2000	or intered events sulting in deeth) Last		Due to (or	r és a conse	equence of):	iven in Pert I.	1 🗆 24a. Wes	Yes 2□ No en eutopsy	3☐ Probably ↓☐Unkno
Was case reterred to medical examiner?    May 03, 2000   Manual completed cause of person who completed cause of death (Item 23a) (Type, Print)   May 03, 2000   Manual completed cause of person who completed cause of death (Item 23a) (Type, Print)   Mass case reterred to medical examiner:   26. Place of Deeth (Check only one)   27. Place of Deeth (Check only one)   28. Dete of Injury at home of UNRNOWN   28. Injury et Work?   1   Yes 2XNo   UNKNOWN   28. Place of Injury at home, ferm, street, factory, office   28. Location (Street and Number of Rural Route Number of City of Town, Stete) of 1 / E. CHASE S   28. Place of Injury at home, ferm, street, factory, office   28. Location (Street and Number of Rural Route Number of City of Town, Stete) of 1 / E. CHASE S   28. Place of Injury at home, ferm, street, factory, office   28. Location (Street and Number of Rural Route Number of Town, Stete) of 1 / E. CHASE S   28. Place of Injury at home, ferm, street, factory, office   28. Location (Street and Number of Rural Route Number of Town, Stete) of 1 / E. CHASE S   28. Location (Street and Number of Rural Route Number of Town, Stete) of 1 / E. CHASE S   28. Place of Injury at home, ferm, street, factory, office   28. Location (Street and Number of Rural Route Number of Town, Stete) of 1 / E. CHASE S   28. Describe how injury occurred   28. Describe how inju							репо		completion of ceuse of deeth?
Menner of Death   1   Nursing Home   2   Menner of Death   2   M	Was case referred to modical					OS Diago -45	oth (Charles	~	70.0
Menner of Death    Menner of Death   Menner of D	examiner?	Hospitel:			-5	ther.		-1	
Contifier (Check only one)   Check only one)   Contifier   Check only one)   Contifier   Check only one)   Check only one)   Contifier   Check only one)		101			ent 3LI DOA	4 U Nursing	4		
2 Accident 3 Suicide 4 Homicide  28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28e. Certifier (Check only one)  28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28f. Location (Street end Number of Rural Poute Number of Ru	_	289. Dete o	Day Year)	TINDAM					Ted Der
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) FOUND AT HOME  28f. Location (Street end Number or Rural Route Number City of Town, Stete) 61 / E. CHASE S  BALTIMORE, MARYLAND  28f. Location (Street end Number or Rural Route Number or Rural Route Number of Nu	2 ☐ Accident investig	5-2.		OTALITA	1[	☐ Yes 2XXVo	UNK	NOWN	
FOUND AT HOME  BALTIMORE, MARYLAND  Certifier (Check only one)  Check only one)  Check only one)  Check only one)  BALTIMORE, MARYLAND  Consider the time, date and place, and due to the cause(s) and menner as steted.  Check only one)  Check one	datam	not ho		me, ferm, s	street, factory, office	0	28f. Location (	Street end Numb	per or Rural Route Number
Date Signeture end title of certifier  (Check only one)  Date Title Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  20 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s)  Description:  21 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  22 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  23 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  24 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  25 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  26 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  27 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner as steed.  29c. License number  O. C. M. E.  May 03, 2000	- Inomicide	buildir	FOUND	AT HO	OME				
Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)	(Check only 2/7 Medical )	Examiner: On the ba	best of my know	wledge des	ath occurred at the	time, date end plac opinion, deeth occ	a and due to the	cause(s) and me	anner es steted
	Menn	: D. Chi	item	i si			1		
Denois D (hute to 111 Penn Street, Baltimore, Maryland 21201  Dete filed (Mopth, Ray, Year), 2000   32. Registrer's Signeture	Dennis J	Chute	no			Street,	Baltimor	e, Mary	land 21201

State Registrar

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 Mary Frances Scott 7:45 p.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Harford Mariner Health Care Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛱 F Yrs 212-82-3779 **Director** 65 Feb. 19, 1935 Maryland Usual Rasidance of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pagas 1 and 2 should be filed within 72 hours aftar daath with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 ehow in your yor other theumatic event, Ite Medical Estimetrial or norther and the model. 10a. State 1 ☐ Yes 2 XNo Maryland Baltimore Director Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4 Dovetail Lane 21221 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yas 2X No Specify: Baltimore, Maryland 21215-0020 à White 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Educetion (Specify only highest greda completed) Elementary/Secondary (0-12) College (1-4or 5+) House Wife 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Harroll Hazel Mae Brewer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Danny William Scott (son) 48 Tommytrue Court, Baltimore, Maryland 21234 20b. Place of Disposition (Neme of cematary, cramatory or other plece) Date 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/8/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) GreenMount Crematory of Fyneral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 a disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, or haart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in daath) /Medical inoma Examiner Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit the death certificate be axecuted Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disease or injury that initiated avants Due to (or as e consequence of): attending physician and P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last for ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? is carnicata has been signed by t director, paga 2 should be detach 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 Yes 21 No 1 Yas 2 No After this cartificata Be 25. Was case referred to medical 26. Placa of Daath (Chack only one) examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 3 No 2 ER/Outpatient 3 DOA the funeral 28a. Date of Injury (Month, Day Year) 27. Manaer of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending investigation Natural Hospital or Attending 24 hours after death.
 Funeral Director; After 25 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) yd ni 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date end place, end due to the causa(s) and manner statad. edical 29a. Certifier To the To the

29c. License number

Street

29d. Date signed (Month, Day, Year)

State

Registrar

29b. Signatura end titla of certifiar

MANNEL

31. Data filed (Month, Day, Year)

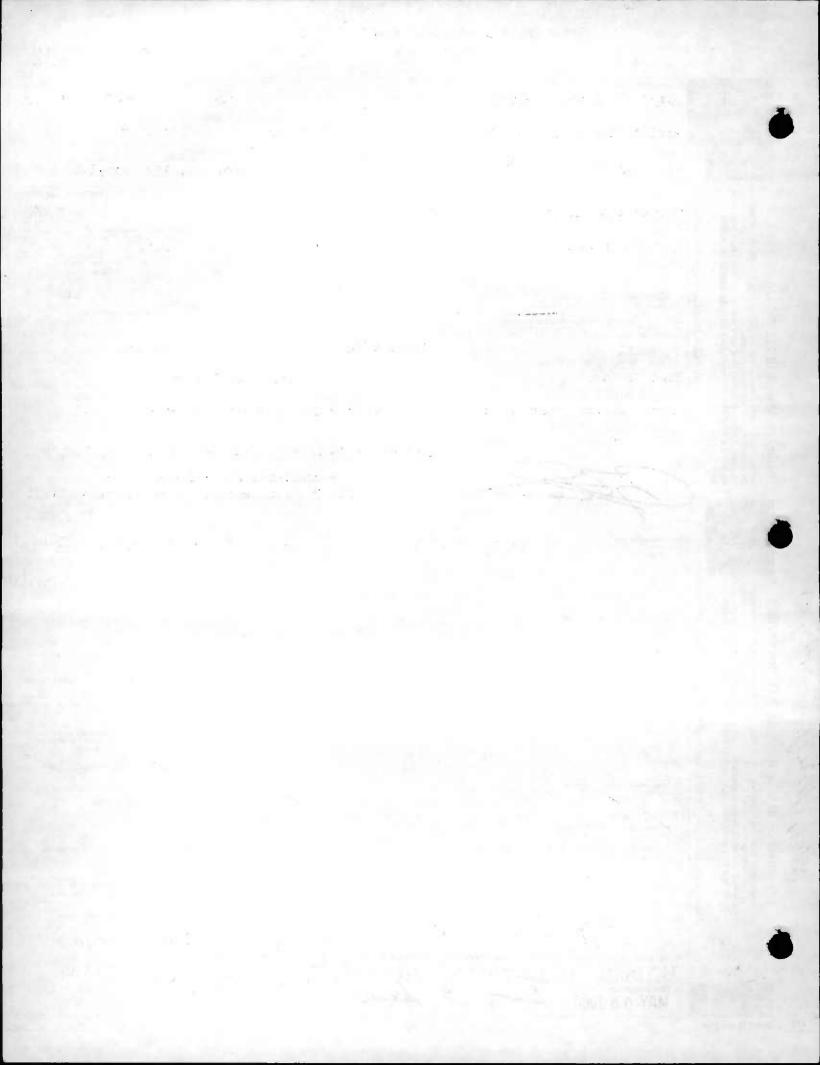
MAY 0 8 2000

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

32. Registrar's Soneture

M.

**DHMH 16 Rev 6/95** 

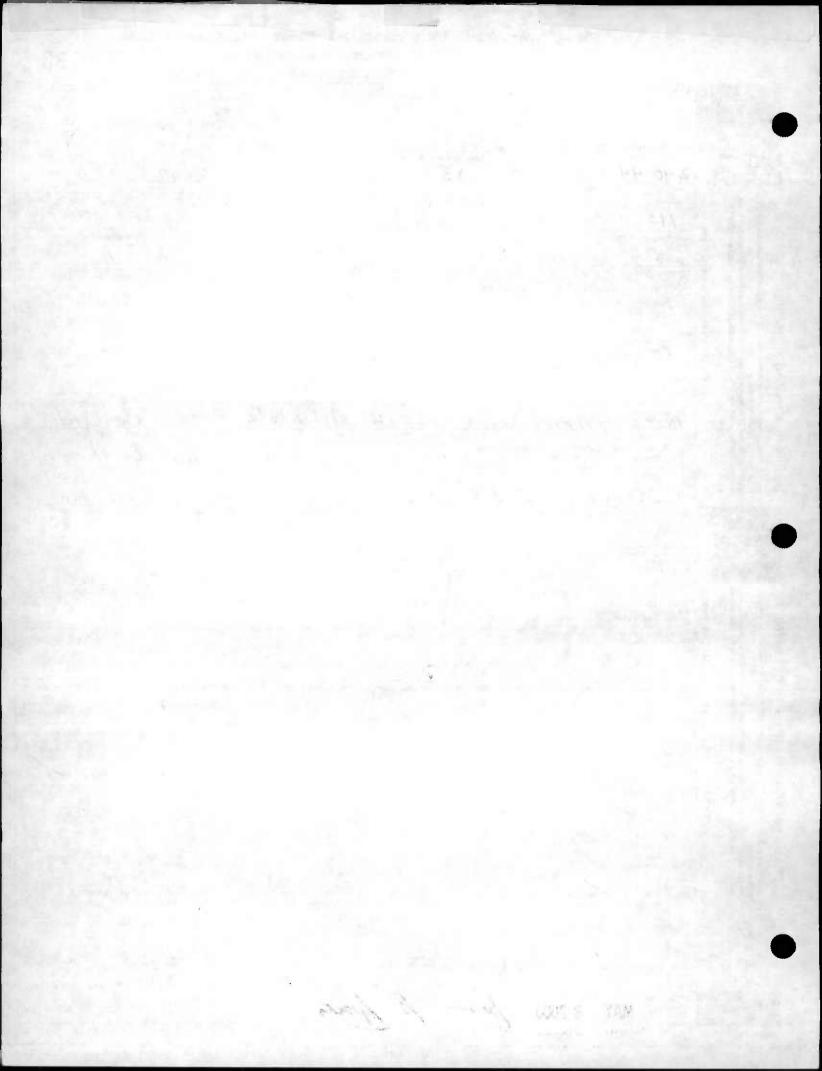


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14693

			Certifica	ate of Death	Re	g. No.		
Dhusisian	1. Decedent'a Nama (First, Middla, La				2. Date of Deeth Month	Day	Yaar 3. Ti	ima of Death
Physician /Medical		Eva	Tayl	or	MAY	_ ′		worm
Examiner	4a Facility Neme (If not institution, giv	a street and number)		4b. City, Town, or	Location of Death	4c. County	of Death	
		BALTIMORE		BALTY				
neral	5. Social Security Number   6. S	Sex 7. Aga (In yrs	2 Yrs. If Unc	der 1 Year If Under 24 Hrs s Days Hours Min	. (Month, Dey,	Year)	9. Birthplaca (S Country)	Stata or Foraig
tor	Usual Rasidance of Decedant		9		1-25-	1917	/	0,0,
4	10a. State 10b. County	10c. C	ity, Town or Location				10d. Ins	sida City Limits
to	Md n	JA R	altimore				15	Yas 2 No
Directo	10e. Street and Number		101. 2	Zip Coda	10	g. Citizan of W	hat Country?	
	2501 VIOL	et Avenue		21215		U.	S.A	
Funeral	11. Marital Status	12. Was Dacedent Evar in U Armed Forcas?	J,S. 13. Wes Dec	cedant of Hispanic Origin? (Specify Cuban, Maxicen, Puar	Specify Yes or No- to Rican, etc.)		- Amarican Ind	ian,
by Fi	1 ☐ Nevar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yas 2 No If Yas, Giva		2 No Specify:		Specify:	0. 4	
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0	17. Father's Name (First, Middle, Last)				ma (First, Middla, M			
To Be Completed	James D. M	c Millan		Katie	Mc Co.	llum		
-	19a. Informant's Name/Ralationship (	Type, Print)	19b. Mailing Addra	ass (Street and Number or R	ural Routa Number,	City or Town,	Stata, Zip Code)	)
	Katie Holme	o-Niece	2204	Allenda	le Roa	d	Balto,	nd
	20a. Method of Disposition		Place of Disposition (A cematery, crametory o	lame of r other piece)	Data 2	20c. Location -	City or Town, St	ata
	1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Specif		ing Me	Morial Park	5-8-00 X	Rand	allsto	un, Mg
N P	21. Signature of Funerel Sarvice Licer	nsaa	22. Name	and Address of Fecility	inst		2	1215
8 8	Thanks	Tres	Marg	W F.H. W	sh- Svan	110 K	Bouls A	41
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Unknown 00-090 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene 00-2147-510 AMEND ITEM: #1 PER MEO G783 Certificate of Death Reg. No. Robin Brockington 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey **Physician** Tyler 18, BROCKINGTON April 2000 2:30 A.M. Robin /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3305 Dorithan Road, Apartment #239 Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months 1 □ M 2 XF Director 212-82-0087 39 M.D. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show na 23a or 28a-f shorman 1 1 Yes 2 □ No Directo Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 U.S.A. 3305 Dorithan Road Apt #239 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. Peges 1 end 2 should be filed within 72 hours after nent of Health and Mentel Hyglene. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Merried ò 21215-0020 1 ☐ Yes XXNo Specify: Specify: þ 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Correctional Officer Patuxent Institute 12th grade na altimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 Douglas Robinson Jr. Dorothy Sampson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Item 27 other tr 21207 3834 North Rogers Ave, Baltimore Md Dorothy Brockington-Mother 20b. Plece of Disposition (Neme of cametery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete Department of Important: If its eny injury or o pace. Muriel 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 4/27/00 Randallstown, 21. Signature of Fugerat Servica Licenses March F/H West 21215 4300 Wabash Ave, Baltimore Md ar Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finat diseese or condition resulting in deeth) Gunshot Wounds of the Head and Arm Examiner Due to (or es e consequence of): Examiner physicien end s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical Due to (or es e consequenca of): for use signed by the e 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? 1 XYes 2 □ No 1 XYes 2□ No of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) To Hospitel: TE Yes 2□ No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Found, Dey Year) 28b. Time of 28d. Describe how injury occurred 27 Menner of Deeth 28c. Injury et Work? Certification: After Division or Attending 5 Pending investigation 1 Naturel Subject was shot. 1 Yes 2 No deeth. Director: A 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) Apartment 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3305 DOLTHAN ROAD 3 4 AHomicide efter Apartment Apt. 239, Baltimore, Maryland Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) end menner steled. edical 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Dete fited (Month, Dey,-Year) 32. Registrer's Signature State MAY 8 2000

Registrar

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

14695 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 4, 2000 **Physician** Tedder Marvin Tien 4:30 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2978 Yorkway Dunda1k Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 10/25/1923 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days Months 10 M 2□ F Hours North Carolina 247-22-7396 76 Director Usual Residence of Decedent deeth with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ahow r 28a-f ahow motified at 1 ☐ Yes 2(XNo Director Maryland Baltimore Dunda1k 10f. Zip Code 10e Street and Number 10g. Citizen of Whet Country? r then "natural", or items 23s or the Wedical Examiner must be 21222 IISA 2978 Yorkway Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerlo Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after one of Haelih and Mental hygiene. and if it flow 27 is marked other than "natural", or flow my or other traumatic event, the Medical Experimany or other traumatic event, the Medical Experimenty. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Soldier U.S. Army 2 years Saitimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Thomas Tedder Mary Ann Lee 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 109 Mountain Rd. Fallston, MD 21047 David A. Tedder Son 20b. Place of Disposition (Neme of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Hilltop Service Corporation 5/8/2000 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furniral Segroe Licensee 22. Neme end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) . Multiogan Faelere
Dy to (or es e consequence of): /Medical Examine Examiner mulo buriel-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest pue Due to (or es a donsequence of) physician s the buriel Box 68760. Physician/Medical Due to (or es e consequence of): 080 P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by should be datac Division of Vitai Records. by 24b. Were eutopsy findings aveileble prior to 24a. Was en autopsy performed? Completed completion of ceuse of death? pege 2 s has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: tha funerel director, edical Certification: To Be 25. Wes cese referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) end menner es steted. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00-9559 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 4940 EASTERW AUE. WATERBURY, MI JHBAC 31. Date filed (Month, Day, Year) 32. Registrer's Mgneture State

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Registrar

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Ma / Co/M 2000 4e Facility Neme (If not institution, give street end number) ocation of De 4c. County of Death ILanc If Under 1 5. Social Security Number 9. Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) Hours Months 1 M 2□ F 212-80-2386 Ma Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No NA Ma 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2120 Madison 54 U.S 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11 Marifel Status Yes 2 No 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Confi 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) NA 2th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Washington Wallace 6. 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Balto, Md Road Vallage Mother 4005 Klisterstown Louise 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Slete 20a. Method of Disposition Dele Burial 2 Cremetion 3 Removel from State Ransladstown, nd 00 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee Nabash quenue Approximele Intervel Between Onset and Dealh 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or head failure. List only one cause on each line. fmmediate Ceuse (Final Bronchoppeumonia disease or condition resulting in death) 15-ease mmunoge ticienu Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 42 Onknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 No 1 Ves 2 No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 Suicide

The lew requires that the deeth certificate be executed Box 68760, the USB 85 P.O. | Division of Vital Records, After this certificate hes ours efter death.

erai Director: After this certifica filled in by the funeral director, p or Attending

by Physician/Medical Examiner Medical Certification: To Be Completed

Physician

/Medical

Examiner

Funeral Director

Be Completed by

**Funeral** 

Director

284-4

23a or

filad within 72

Pages 1 and 2 should be

altimore,

and Mental Hygiene. Is marked other than

Appartment of Health Important: If Nem 27

**Physician** /Medical

Examiner

To the Hospital c within 24 hours of To the Funeral D completely

Registrar

**DHMH 16 Rev 6/95** 

e and eddress of person 31. Dete filed (Month, Dey, Year)

4 Homicide

29b. Signature and talk of partilla

29a Certifier

5 32. Registrar's Signeture

Certifing Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steled.

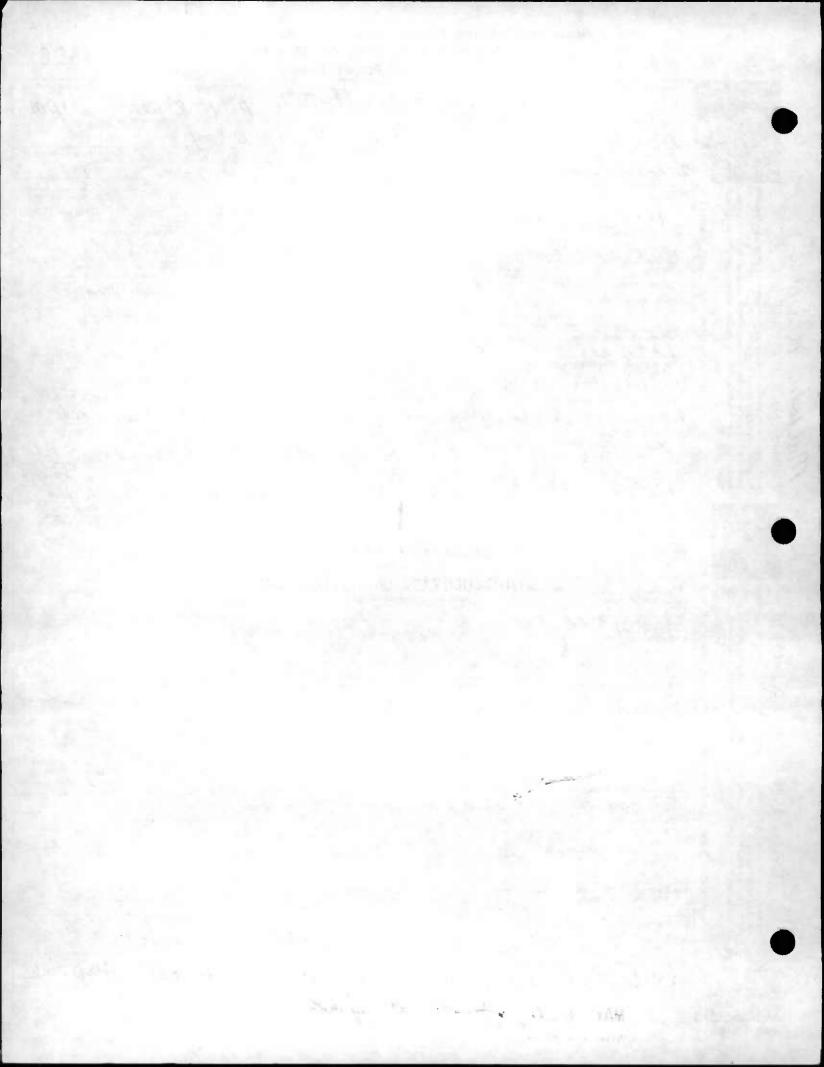
29c. License number

29d. Date signed (Month, Dey, Year)

2

**ORIGINAL** 

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



Saint Joseph Medical Center Towson	ounty of Death
	ounty of Death
	Baltimore
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
Director 218-42-3974 54 18 03-01-46	MD
Usual Residence of Decedent	
10a. State   10b. County   10c. City, Town or Location   MD   NA   Baltimore   10d. Zip Code   10g. Citizer   2135 E. Chase Street   21213   U   11. Maritel Status   12. Was Decedent Ever in U.S. Armed Forces?   11. Maritel Status   12. Was Decedent Ever in U.S. Armed Forces?   11. Never Married 2   Married   11. Yes 32 No   11. Yes specify Cuban, Mexican, Puerto Rican, etc.)   12. Yes Give Year or Dates:   15. Decedent's Education   16b. Kind of Give kind of work done during most of working life. Do NOT use retired)   16b. Kind of Give kind of work done during most of working life. Do NOT use retired)   12. The Grade   NA   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)   1. Decedent's Usual Occupation (G	10d. Inside City Limits
MD NA Baltimore  10e. Street and Number  2135 E. Chase Street  11. Maritel Status  1	MON es 2 □ No
10e. Street and Number 10f. Zip Code 10g. Citizer	n of What Country?
2135 E. Chase Street 21213	SA
2135 E. Chase Street 21213 U  11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced  21213 U  12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, Give Year or Dates: 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	Race - American Indian,
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
1 Never Married 2 Married 1 Yes 3 No Hyes, Give Year or Dates:  1 Yes 2 No Specify: Sp	pecify: Black
3 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working	of Business/Industry
Elementary/Secondary (0-12)   College (1-4or 5+)   Laborer   Tows	gon University
17. Fether's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sui  Karl Walker, Sr. Irene Rando	son University
17. Fether's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sur  Karl Walker, Sr. Irene Rando  19a. Informant's Name/Relationship (Type, Print)  19b. Maiting Address (Street and Number of Bural Route Number. City or To	manoy
Karl Walker, Sr. Irene Rando	
19a. Informant's Name/Relationship (Type, Print)  19b. Maiting Address (Street and Number or Rural Route Number, City or To	
Elementary/Secondary (0-12)   College (1-4or5+)   Laborer   Tow:  12th Grade   NA   Laborer   Tow:  17. Fether's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sure Name (Firs	e, MD. 21218
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Locat	tion - City or Town, State
E O I LABURIA 2 LICTEMATION 3 LIMEMOVALITOM STATE	timese MD
5 5 de 21. Signature of Funeral Service Licenses 22. Name and Address of Facility D = 3 L 3	aryland 21202
WM.C.March FH 1101 E. North	aryland 21202
WM.C.March FH 1101 E. Nort	th Avenue
disease or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d	
Da B	
d	
	e contributs to the cause of death
*6 A	
1 Yes 2 P	No 3 Probably 45 Unknow
24a. Was an autopsy	24b. Were autopsy findings
24a. Was an autopsy performed?	aveilable prior to completion of cause
5 0 <u>0</u>	of death?
1 Yes 2 1	No 1 ☐ Yes 2 X No
0 25 Was case referred to medical	
Hospital: 1 Inpetient 3 DOA Other: 4 Number 4 Depidence of Doa Other:	Other (Specify)
( = 1 TO V = 0 TO V =	
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and N	lumber or Rural Route Number,
2 Accident Investigation 2 Accident Suicide 3 Suicide 4 Homicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and N City or Town, State)	Total Troute Training
3 Suicide 4 Homicide  4 Suicide 5 Suicide 5 Suicide 5 Suicide 6 Su	d manner as stated. aca, and due to the cause(s)
one) and manner stated.	
	igned (Month, Day, Year)
	il 28 2000
30. Name and address of person of completed cause of death (Item 23a) (Type, Print)	
BEATRIZ DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND	21204

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

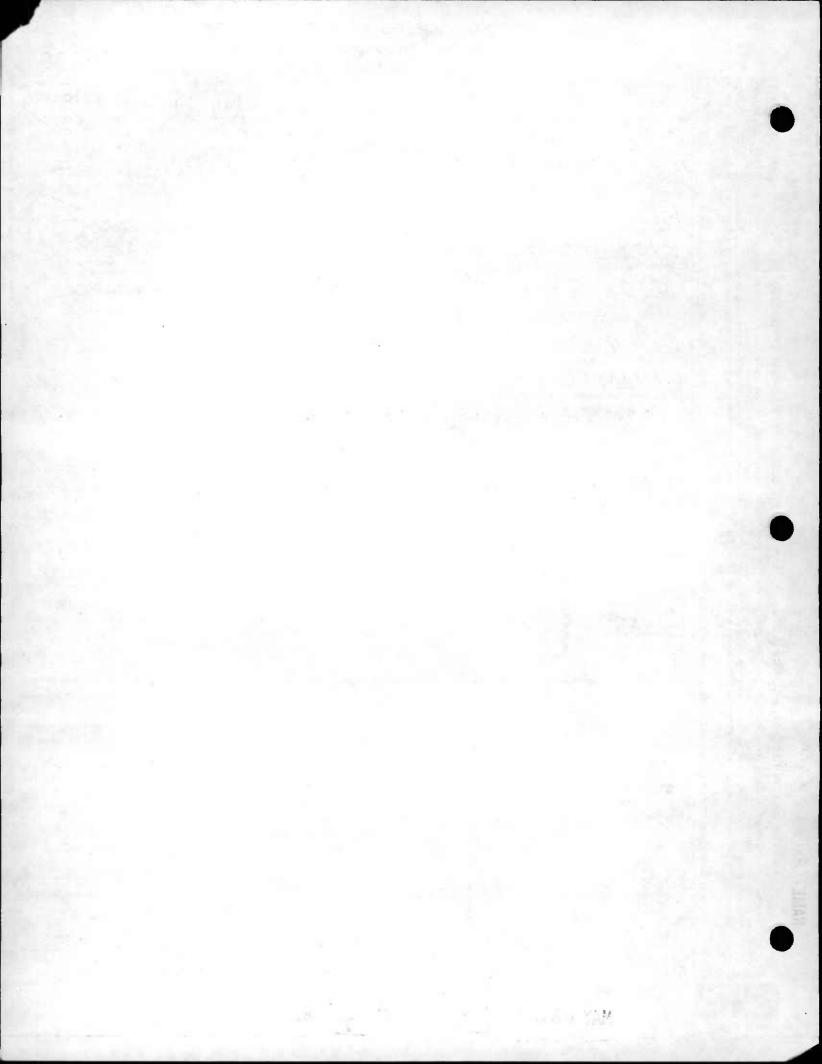
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Yeer **Physician** Month 615 PM Mar MABLE WILSON 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner St. Agnes 1405pital Baltimore 5. Social Security Number Birthplace (State or Foreign Country) A Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F 212-22-068 Yrs 50 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits to or 28a-f show 1 € Yes 2 □ No Funeral Director BALTIMORE 10e. Street end Number 10g. Citizen of What Country? deeth with 3803 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) me 23a U5A 12. Was Decedent Ever in U,S.
Amed Forces?

1 Yes 2 No
K Yes, Give or items 14. Race - American Indien, Black, White, etc. 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours effer d Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Evantina. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: BLACK it Tes, Give Year or Dates: Be Completed by 3₽Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MCCLEAR WILLIAM 6 GRICE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO, MID UOHN STOKES DRIVE, WILSON (SON 3803 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) 5-5-00 £1011 21. Signature of Funeral Service Ucens 22. Name and Address of Fecility 4/600 LI BERTY HEIGHE AVE Michael BALLIMURE HOWER FUNDING HOUR hat caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, on each line. 23a. Part1. Enter the disease, or comp shock, or heart failure. List only Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Vascular any Examiner Due to (or as a consequence of) Physician/Medicai Examiner or Attending Physician: The lew requires that the deeth certificate be executed for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown funeral director, pege 2 should be detact 1 Yes 2 No ģ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitef: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. fnjury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural deeth. 1 Yes 2 No 2 Accident after deeth Director: 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) In by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled In 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner steted. Medical 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 135 2000 30. Name and address of person who completed cause of death (ftern 23a) (Type, Print) 900 Ave Tom Balshi mi) Caton 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 16 Rsv 6/95

**ORIGINAL** 



Piease Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a,27 per phys. yg G783 5/8/00 yg

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Whitehurst April 3:41PM Robert E. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltinne NA If Under 24 Hrs. 8. Date of Birth Hours | Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F 216 34 3738 M. Carolina 62 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No Director Mary Inus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pemit. Peges 1 and 2 should be filed within 72 hours effer death with 1 Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 2 withjury or other treumatic event, the Medical Examiner must be noted. 21239 USB Winston AVE 1202 Funeral 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married 1 Yes 2 Ho If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specity: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BEXLEHEM Steel Elementary/Secondary (0-12) College (1-4or 5+) 12 H grafe 17. Father's Name (First, Middle, Last) Steelburken 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 BLANCHE Hetis JE0198 1. WHITEHURST, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BALHAUN, Mery/mo 21239 Macion Whitehurst 1202 WINSHIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) HUBUTUS, marylows (Arts 22. Name and Address of Facility CHATMAN - HARRY Fineral Hime 5340 RENSTERGIUM RENO 21. Signature of Funeral Service Mounses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Death UROSEPSIS Physician Immediete Cause (Final disease or condition resulting in death) /Medical PEA Arrest 30 min Examiner Due to (or as a consequence of) Physician/Medical Examiner CORANARY ARTERY DISEASE 35min radycard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Guillan Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Ď 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy 1 X Yes 1 Yes 2 No 2 No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

physician and a the buriel-transit The law requires that the death certificate be exacuted Box 68760. P.O. 1 sete has been signed by the a page 2 should be deteched Records, certificate of Vitai or Attending Physicien: Certification: To this funeral Division After To the Hospital or Attending within 24 hours efter deeth.
To the Funeral Director: Afte completely filled in by the fun

**ehow** 

21215-0020

Baitimore, Maryland

1 Yes 2 40 27, Manner of Death

Bending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

29a. Certifier (Check only one)

1X Natural

2 Accident 3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier mor MO

Res000

29d. Date signed (Month, Dey, Year) April 29, 2000

Baltmare Maryland 21224

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stasic Stath Reynolds 4940 East Eastern Arenue

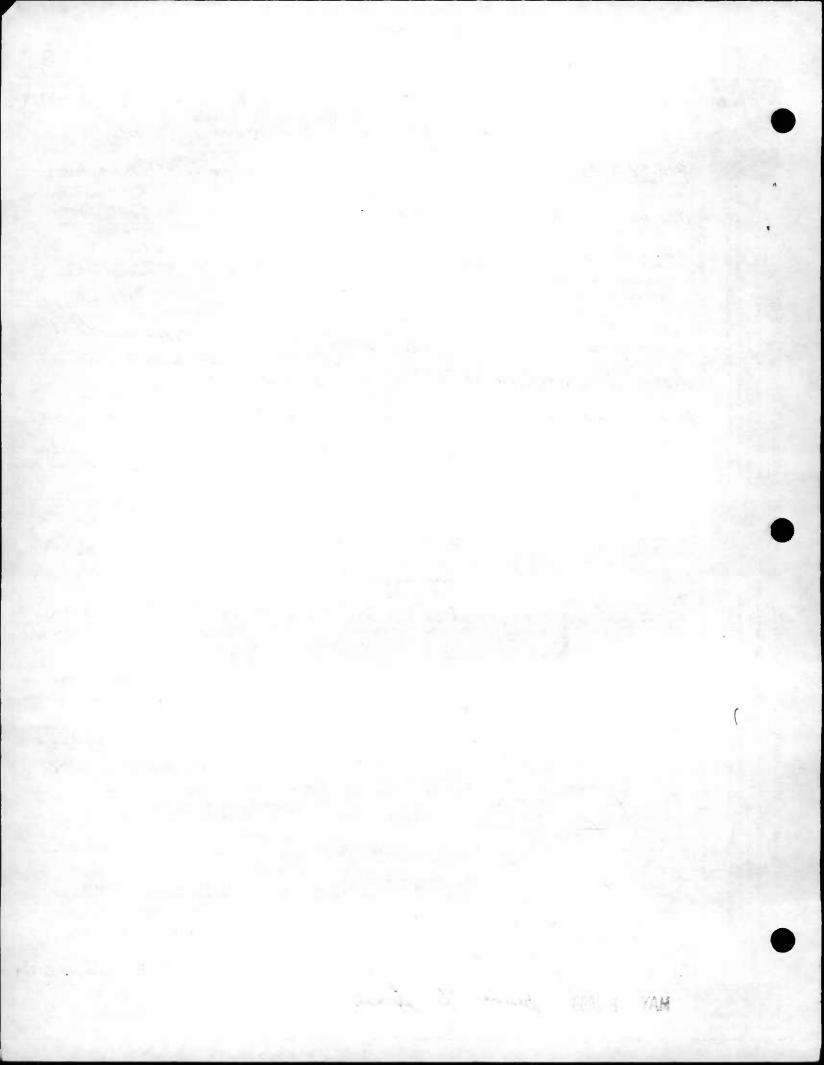
State Registrar

Medical

31. Date filed (Month, Day, Year) 8 2000

32. Registrar's Signature

Dacks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 03, 2000 Mary Margaret Waldt 1:20PM May 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Timonium Baltimore Stella Maris Hospice 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. Data of Birth (Month, Day, Year)
Une 8,1926 Birthplaca (State or Foreign Country)

Md 7. Aga (In yrs. last birthday) Months Days Hours 1□M 2√2F 73 Yrs. 219-22-0486 Usual Rasidance of Decedant 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location N/A Baltimore 1 X Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 2829 Overland Ave. U.S.A. 12. Was Decedant Evar in U.S. Armed Forces? 14. Race - American Indien, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 No If Yas, Giva 1 Never Merried 2 Married White 1 ☐ Yes A(XNo Specify: Specify: 3℃Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) Balto. City Circuit 12 Supervisor Courts 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) DR. Thomas Francis White Teresa Genevieve Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 3712 Ridgecroft Rd Baltimore, Md 21206 Patrick M. Waldt 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 10 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Holy Redeemer Cemetery 5/06/2000 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensea Matthew T. Canapp. Nama and Addrass of Facility 5305 INC. Harford Rd Baltimore Md 21214 Leonard J. Ruck anoy 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaese or condition rasulting in death) CHRONIC OBSTRUCTED PULMONARY DISEASE Dua to (or as a consequence of) Sequantially list conditions, if any, leading to immediata causa. Entar Undarfying Cause (Diseesa or injury that initiated avents rasulting In death) Last Due to (or es a consequance of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yas 2 X No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Mary Waldt Viital jo

attending physicien and for use as the buriel-transit Box 68760. requires that the dasth certificate be signed by the a page 2 should The lew certificate Attending Physician: director this funaral Affer Division daath. Hospital or Attendi
 24 hours altar daath
 Funeral Director: A within 24 hours altar death To the Funeral Director: completely filled in by the

Physician

/Medical

**Examiner** 

Md

Director

Funeral

À

Completed

Be

**Funeral** 

Director

28a-f show

6

'natural', or items 23s

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if Item 27 is marked other than any Injury or other traumatic event, the page.

**Physician** 

/Medical

Examiner

Physician/Medical Examiner

þ

Be Completed

Baltimore, Maryland

2000

3,

filed within 72 hours after Hygiene.

Medical Certification: To To the State Registrar

29b. Signature and the of cartifian

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29c. License number

TIMONIUM, MD 21093

29d. Data signed (Month, Day, Year) 15/00

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

TARIQ MAHMOOD 31. Data filed (Month

2300 DULANEY VALLEY RD.

1344 . . . . . **DHMH 16 Rev 6/95** 

29a, Certifier

frame to sport

0000 8-0 YAM

IRENE ALLEN Records, P.O. Box 68760, of Vital or Attanding Physician: **Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

10a. State

MD

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Merylen Department of Heelth end Mentel Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show any Injury or other traumatic avent, the Medical Exemples must be notified at page.

**Physician** /Medical

Examiner

attending physicien end I for use es the buriel-transit

21215-0020

Saltimore, Maryland

pege 2 s 215-16-4853 this Division After deeth. hours after deeth 24 hours To the Fune completely f To the Vithin 2 2 This

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. ð Completed Be 25. Was case referred to medical 1 Yes 2 No Certification: To 27. Menner oi Death 1 Natural 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end marrier stated.

31. Date filed (Month, Day, Year) 2000 State Registrar

29b. Signature and title of certifier

D.B. Steatt i 205 JOHNSON MEIGHTS. MEDICAL BUILDING, CUMBERLAND, MD 21502. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

29c. License number

23334-D

29d. Date signed (Month, Day, Year)

APRIL 255 2,000.

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APR 27 2000 Genera & Sporter

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #26 PER PHY G783 5-24-00 WR. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dey Month **Physician** Susan Burch 10:00 a.m. Amrein April 12, 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 16076 Thomas Road Piney Point St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 1 □ M 2 M F Yrs 95 Director 218-09-6886 30,1905 | Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Motical Examinat must be included. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2 No Directo Maryland St. Mary's Tall Timbers 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 17762 River Shore Drive Funerai 20690 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife N/A 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be William B. Burch Susie Combs 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Suzanne C. Poe / Niece 16076 Thomas Road, Piney Point, Maryland 20674 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ■ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) rinsfield-Echols 4-13-00 Charlotte Hall, MD 22. Name and Address of Facility Funeral Service Lic Brinsfield Funeral Home, P.A. Brinsfield r

Edward N. Brinsfield Jr. M00052 22955 Hollywood Road, Leonar

23a. Part1. Enter the disease, or complice this that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Carcinoma **Examiner** Due to (or es e consequença of) Examine metastatic attanding physician and for use as the burial-transit The law requires that the death certificets be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of deeth? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ģ been sig 24b. Were eutopsy findings evaileble prior to completion of cause of deeth? 24a. Wes en eutopsy Completed ils certificate hes b I director, paga 2 sl 1 Yes 2 No 1 ☐ Yes 2 ☐ No tal or Attending Physician: The star death.

Is after death.

In Director: After this certificate of in by the funaral director, pa Be 25. Was case referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home -5 Residence 6 Other (Specify) HAESE 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpetient 3 | DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Yeer) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier DO 1380 2000 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) John F. Fenwick, M.D., Medical Arts Building, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

USTIN LAWRENCE BATES

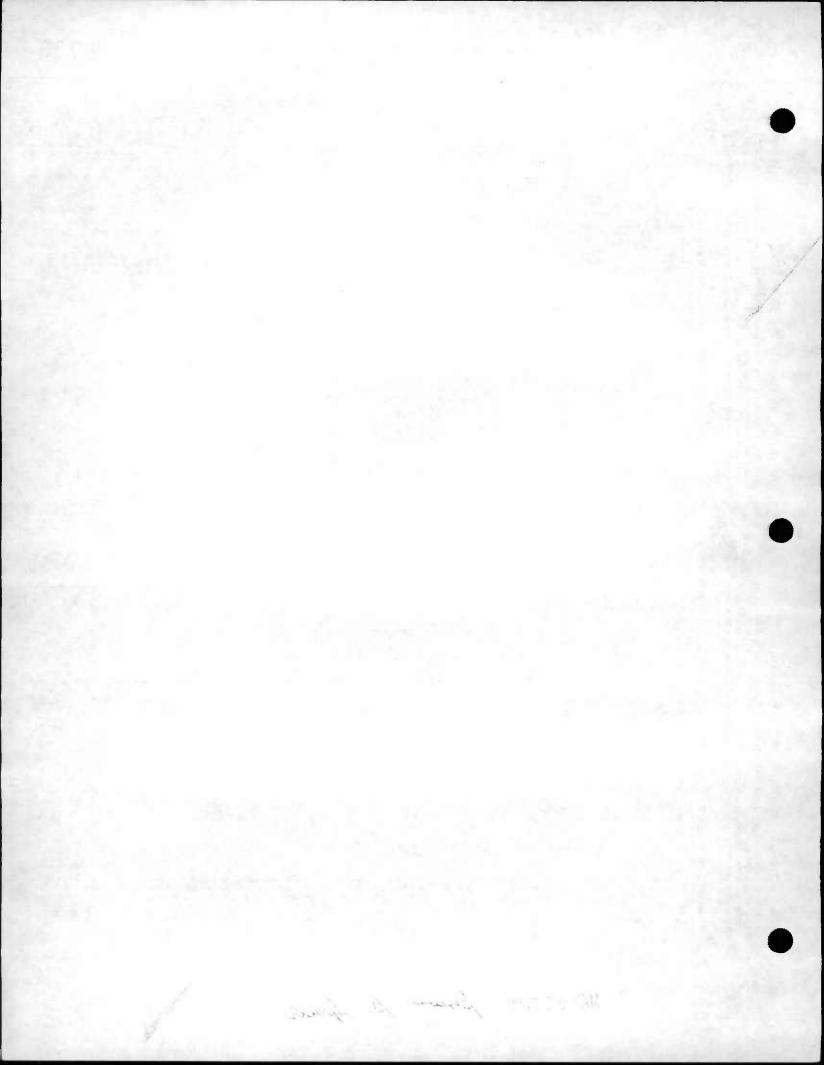
State of Maryland / Department of Health and Mental Hygiene 0 1 14703

AMEND ITEMS: 23 PART I, 27, 28A-F PER MEO Certificate of Death

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any injury or other tr DDC8.	20a. Method of Disposition 20b. Place of Disposition (Nama of	Data	T									
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5	Br nsfield-Echols 5-2-00 Charlotte Hall, MD											
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	Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, Maryland											
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DHMH 16 Rev 6/95



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () ()

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Examiner must be notified at by Funeral Director		Alleg	any	100.00	-	erla	ind						M Yas	
rect	MD 10e. Street and Old Tow					10f. Zip	Coda				10g. Citizan o	What Cou	intry?	
a O	Old Tow	me Manor	Apts.					2150	2					
Funeral	11. Marital Statu	s	12. Was Deci	edent Evar in U	,S. 13. \	Was Deced	lant of Hi	spanic Ori	gin? (Sp	ecity Yas or N Rican, atc.)	0- 14. Ra	aca - Amari ack, Whita	ican Indian, . atc.	
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8	4 Donation 5 Other (Specify)  Sunset Memorial Park 4/19/ Cumberland  21. Signature of Funaral Sarvice Licensee  Scampe Lduriss of Funaral Home P.A.  Cumberland, MD 21502													
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	23a. Part1. Ente	ar tha disease, or conneert feilure. List only	pications that o	seused the daat	h. Do not ent	er the mode	e of dyin	g, such es	cerdiac	or respiratory	arrast,		Approximat Intarval Bet	
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miner	rasulting In deat	th)		Dua to (d	or es a conseq	juence of):							Two s	
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State of Maryland / Department of Health and Mental Hygiene

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		Ť		Certificate o	f Death		Reg. No.		1700	
		1. Decedent's Name (First, Middle, Last)			2. Dete of Dec		Vans	3. Time of Deeth		
3.	Physician /Modical	VIOLA CATHERINE	BURLEY		APRIL	17 200	Yeer	2:28 PM		
1	/Medical Examiner	4e Facility Neme (If not institution, give s	treet end number)		4b. City, Town, or L				2.20	
- 1		EGLE NURSING HO	ME		LONACON	ING	ALLE	ZANV		
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthdey) If Under 1 Ye	ar If Under 24 Hrs.	8 Date of Birt	h	9. Birthpl	lece (Stete or Foreign	
L	Director	219-14-5637 Usuel Residence of Decedent	M 21X F	Yrs. Months De	ys Hours Min.	AUG 2		MAR	YLAND	
	yang M	10a. Stete 10b. County	10c. City,	Town or Location				10	0d. Inside City Limits	
	or 28e-f st be notified Director	MARYLAND ALLEG	ANY F	ROSTBURG					1 ☐ Yes 🎾 No	
		100. Street end Number	LANE	10f. Zip Code 2 1 5			10g. Citizen of W	thet Count	try?	
5-0020	curs after death v Examiner must Examiner must	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 D Noivorced	2. Wes Decedent Ever in U,S Armed Forces? 1 □ Yes 2√□ No If Yes, Give Yeer or Dates:	13. Was Decedent of If Yes, specify C	If Hispenic Origin? (Spuben, Mexican, Puerto lo Specify:	pecify Yes or No Rican, etc.)		k, White, e	an Indian, etc. HITE	
5	72 h natu ásal ásal	15. Decedent's Educ (Specify only highest grede	eation completed)	16e. Decedent's Usual Occ (Give kind of work doi	cupation	kina	16b. Kind of Bu	siness/Ind	dustry	
2121	ygiene. yerihen "natur A. the Medical.	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT use ret	ired)	, and	RESTA	URAN	V T	
		17. Fether's Neme (First, Middle, Last)		0001	18. Mother's Nam	ne (First, Middle,			11	
Maryland	Montal H Montal H srked off stile ever	ROBERT BEAN	NE MEL	VINA S	IRES	5				
ar	S a sh	19e. Informent's Name/Relationship (Ty)		19b. Meiling Address (Stre	et end Number or Ru	ral Route Numbe	er, City or Town,	State, Zip	Code)	
-	and a 27 ar tr	ALBERT L. BURLE	Y/SON	1410 BROCKE	BRIDGE RE	)., LAU	IREL, MD	207	724	
Baltimore	ages 1 ant of Hs t: If Nam y or oth	20a. Method of Disposition  1 ☑ Buriel 2 ☐ Cremation 3 ☐ R: 4 ☐ Donetion 5 ☐ Other (Specify)	emovel from State cer	nce of Disposition (Neme of metery, crematory or other p	APKIL	Date 20,20	20c. Location -			
重	artmer ortant injury 8.	21. Signature of Funerel Service License		STBURG MEM		K K	FR0S1	BUR	G,MD	
B	Depar Impor any in	1		HVEED C	UADEL AE	THE H	ILLS MO	)RTU/	ARY	
		23a. Part1. Enter the disease, or complishock, or heer feilure. List only on	cations that caused the death. e cause on each line.	Do not enter the mode of o	I I O N A L H lying, such es cardiec	or respiretory e	ALE, MD	215	Approximete Intervel Between	
	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition	Cardion	yora thy					Onset and Death	
		resulting in deeth)	Due to (or	as a consequence of):	~ .				0	
	executed in and sial-transit	_ b	Coronar	y arter	, Disco	LSE		-	Lyear	
	be executed clan and burial-transit al Examir	Sequentielly list conditions, if env, leading to immediate cause. Enter Underlying Couse, Disease or Injury  Due to (or exe)consequence of):								
68760	physician s tha buria	Cause. Enter Underlying Ceuse (Diseese or Injury that initieted events	4!	2 years						
68		resulting in deeth) Lest	(Pue to (or e	es a consequenca of):		N	^	7		
Box		d	Genera	r Terro	eno sclero sis					
0.	e death he atter ned for u	Pert II. Other significant conditions con	tributing to death but not result	ting in the underlying cause	given in Pert I.	23b. Did 1	lobacco use cor	tribute to	the cause of death?	
0	s that the	Chonic O	bstruction	re Pulm	mary Dix	age 10	Yas 2□No	3 ☐ Prob	bably Unknow	
Records,	The law requiras that the death of the last been signed by the attendage 2 should be detached for uncompleted by Physician	Congestive	Leart fa	ilura	1	24a. Wes perfo	an eutopsy rmed?	COF	ere eutopsy findings eilable prior to mpletion of cause	
	has ya 2	Cohami	(			10,	res 2 No		deeth? □Yes 2□No	
Vital	certificate rector, pag	25. Was case referred to medical	anem		26. Place of Dea	th (Check only o	nne)			
f <	Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpelient 3 DOA	Other: 4 Nursing H	ome 5 Resid	dence 6 □Othe	ar (Specify	(v)	
on of	fter free	27. Menner of Death  1 Naturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)		ijury et Vork? □ Yes 2 □ No	28d. Describe	now injury occurr	ed		
Division	tal or Attending P rs aftar death. at Director: After t lad in by the funere Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At hom building, etc. (Specify)	ne, farm, street, fectory, office	ca	28f. Location (S City or Tox	Street end Numbern, Stete)	er or Rure	I Route Number,	
	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification	29a. Certifier 1 Certifying Phys	Ician: To the best of my knowler: On the besis of examinetic	ledge, death occurred et the	time, date end pleca	, end due to the	cause(s) end me	nner es st	teted.	
	the H thin 24 the Fi	one)	and menner stated.							
	11	29b. Signature and title of cartifier		29C. LICE	ense number		29d. Date signed			
	4	Jarules	MAD		00700° 39 MD L	4 (	ipul	19,	2000	
	hes	30. Name end eddress of person who	V -		39	RNI	IEC T	e L	10	
	,	57 JACKSON	DI. LON	ACONING, 1	AID P	.11.111	-w, v	. /		

DHMH 16 Rav 6/95

State Registrar

57 JACKSON
31. Dete filed (Month, Dey, Year)
APR 2 4 2000

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AND THE RESERVE OF THE PROPERTY OF THE PROPERT

State of Maryland / Department of Health and Mental Hygiene 14706 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician Dorothy Brickey 24, 2000 02:45 A.M. April /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Cumberland Allegany Months Days Hours Min. 8. Date of Birth (Month, Dey, Year)

Jan 28, 1924 5. Social Security Number Birthplece (State or Foreign Country)

WV 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2□F 76 Yrs. 235-34-8852 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. tnside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Exercises must be notified at 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1 Baltimore Street Apt. 416 21502 USA Funeral 12. Wea Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Black, White, etc. filad within 72 hours aftar of Hygiana. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1□ Yee 2□No Specify Specify: white 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pagas 1 and 2 should be filad will Department of Haelth and Mental Hygian Important: If Item 27 Is marked other tha any Injury or other traumatic event, that page. Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Paul Shelton Allie (Basham) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Katherine Madden 10000 Shinnamon Drive; LaVale MD 21502 20a. Melriod of Disposition 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Scarpelli Funeral Home4/24/ Cresaptown, MD 21. Signature of Funeral Service Lie Scarpelli Funeral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Link only one cause on each line. Approximete Intervet Between Onset end Death **Physician** Meta Static hing Cancer Immediate Ceuse (Final disease or condition resulting in deeth) /Medical 2 mourt Examiner Due to (or es a consequence of):/ Physician/Medicai Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of) P.O. Box 68760. requires that the daeth certificate be that initieted events resulting in death) Last Due to (or es a consequence of) Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? Backered Hypertens con, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Records. 24b. Were eutopsy findings eveilable prior to completion of cause Completed 24a. Wea en eutopsy 1 ☐ Yes 2 No 1 Yes 2000 certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 10 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No **₽** Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. Medical 29e. Certifier 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number Homa Grahil MD 2000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) Shakil M.D. 625 Kent Ave Cumberland MU 21502 31. Dete filed (Month, Dey, Year) State APR 2 4 2000 Registrar

1005 KS 1994

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Vear **Physician** RALPH GEORGE 2000 APRIL 2:45 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 1 M 2 F Months Yrs Director 213-05-7142 02-Dec-05 Maryland Usuel Residence of Decedent with the Maryland 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 26a-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Allegany Frostburg 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 19920 Old Midlothian Road death Funeral 14. Race - American Indien, Black, White, etc. 21.532-12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Merital Status hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) owner/operator school buses psemit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If then 37 is marked other
any injury or other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 **Nellie Smith** Robert Brain 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Midlothian Maryland 21543-Verla Williams daughter P.O. Box 305 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition

1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 25-Apr-00 Frostburg, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Mu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximete Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final 5 years diseese or condition resulting in deeth) a Cancer of Prostate Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) esn ed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed Deen The law page 2 s cartificate has 1 Yes 2 No 1 ☐ Yes 2 No of Vital 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending ours after deab. 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 124 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier D0014865 APRIL 24, 2000 2 ( obustice / Juna, 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ny DR. AVE., ROBUSTIANO BARRERA, 500 MEMORIAL CUMBERLAND, MD 21502 APR 2 6 2000 32. Registrar's Signetur State Registrar

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Maryland 21543-	Midlothian	305 xc3	eider	is d	Vada William
Frostburg Maryland	25-Apr-00	Production we more how			

Burst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

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	J.	Bro	wn	Jr.	APRIL	19,2000 Y	997	3:15 A.M.				
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eture of Funeral Sen	rice Licensee	Marcell	Scarpel 1			P.A.						
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Suicide 6 □ Co	puld not be termined 28e.	Place of Injury - Al home, fa building, etc. (Specify)		Yes 2 No	28f. Location (Si City or Town	reet and Number n, State)	or Rurel F	Route Number,				
Pa. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
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nal	ture and title of ce	k only 2 Medical Examiner: On end ture and title of certifier	ture and title of certifier  Medical Examiner: On the basis of examinetion en end manner steted.  Turn and title of certifier  MATYASIK	ture and title of certifier    Continued and title of certifier   Continued and title	ture and title of certifier    A   C   Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occur end manner steted.    C   C   C   C	ture and title of certifier    Agry   Content   Content	ture and title of certifier    April   April   April	ture and title of certifier    April   April				

DHMH 16 Rev 6/95

199 27 2000 General & speed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 27, Myrtle Brown Apr 2000 10:00am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Devlin Manor Nursing Home Allegany Cumberland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□F Months Yrs. 216-22-6733 89 1910 Director MD Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. inside City Limits 28a-f show permit. Pagas 1 and 2 should be filad within 72 hours after death with the Merylai Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page. 1 Yes 2 No Director Allegany Cumberland 10g. Citizen of What Country? 220 Somerville Avenue Apt 708 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□Yes 2□No Specify White Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retired Celanese 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Oliver Jenkins Ella M Hite 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara Webster 12418 Pine Tree LnSE; Cumberland, MD 21502 da want of Bisposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Par5/01/ Cumberland, MD 21. Signature of Funerel Service Licenses Scarpelli Funeral Home P.A. Cumberland, Maryland 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** with Group D Entrocacio Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The lew requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 2/2/No 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica complatally filled in by the funarel director, p. 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) wa D54411 Apr 27, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Ray 6/95

Beverly M.

31. Date filed (Month, Dey, Year) APR 2 8 2000

Calkins M.D. 500 Memorial Ave Ste 105 Cumberland MD 21502 32. Registrar's Signature

APR 2 8 3007 January & Species

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Phys	ician	Decedent's Nan     Edward	na (First, Middle, L.	ast)		Bacor	2				2. Data of D Month April	eath 19, Day	2000 Year	3. Tima of Death 7:00 AM
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Fune: Direct	_	5. Social Security 083-42-	Number 6.	Sex W∑M 2□F		(In yrs. last		If Under 1 Y Months Da	aar	If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D 12-10-		9. Birthplaca (Stata or For Country) N • Y •	
Pung Man		Usual Residence of 10a. Stata	10b. County			10c. City, T	own or Loc	ation	_					10d. Insida City Limits
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r 28e	5	10e. Street and Number						10f. Zip Cod	de			10g. Citiz	en of What Co	untry?
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15-0 in 72 ho	Maryland 21215-0020 d 2 should be filed within 72 hours after th end Mentel hygiens. 7 is marked other then "natural", or its traumatic avent, the Medical Exercise To Be Completed by Fu		ducation ade completed	)	1	6a. Decede (Give k	ent's Usual Oci ind of work do O NOT use re	ccupa one d	ation luring most of work	ing	16b. Kin	d of Businass/I	ndustry	
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Box 68760, eath certificate be asscuted attending physician and ifor use as the busis-transit	clan/Medical Examiner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event rasulting in death)	S	b	oac	oua to (or as	~	Fes						Marchan Tyron, matter
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Cords requires been sign	Completed by Phys	1 ☐ Yes 2 ☐ No  24a. Was an autopsy pertormed?								sy 24b. V	Vara autopsy findings ivailable prior to complation of ceusa of death?			
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Ysician: The ysician: The servificate director, pag	Be	25. Was casa refa	rred to medical							26. Place of Deat	h (Check only	ona)		
On of ding Phys After this funeral di	ation: To	1 Yas 200	th 5 Pending investigation	28a. Data (Mor	Inpatient of Injury oth, Day	jury 28b. Tima of 28c. Injury at			/ at	ma 5□ Ras 28d. Describe			ify)	
D 9 4 5 1	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	289. Plac	e of Injury ling, etc.	y - At homa (Specify)	ı, farm, sire	et, factory, of	fice			(Street and own, Stata)	Number or Ru	ral Route Number,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)		miner: On the b		xamination				na, data and place, pinion, daath occuri				
To th To th	ž	29b. Signatura and	titla of certifier	2/	10	,		29c. Lic	censa	number	9	29d. Data	signed (Month	i, Day, Year)

Registrar

State

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Robins, M.D. 1104 Healthway Dr., Salisbury, MD

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year Thelma Jane Banks April 1500 17,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 24 Hrs. H Under 1 Year 8. Date of Birth (Month, Day, Year) 6-13-1931 Birthplace (Stata or Foraign Country)\_\_\_\_ 5. Social Security Number 7. Age (In yrs. last birthday) Days 10 M 20 F 68 218-40-6296 Yes DE. **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yas 2 No Hebron Wicomico Md. 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 USA Box 90 211 Lillian St. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes XXNo Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Garment Co. Assistant Manager 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) Walter Hastings Myrtle Hastings Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Lillian St. Box 90 Hebron, Md. 21830 Mabel L. Banks, Daughter 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Di Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhill Memory Gardens 4-20-00 Hebron, Md. 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 llam Approximata Intarval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) Due to (or es a consequence of). Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No 1 Yes 1 🗆 Yas 2LI No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2/2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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permit. Peges 1 and 2 should be filled within 72 hours effer death with the Meryle Department of Health and Mentel Hyglens. Important: If item 27 is marked other than "naturel", or items 23s or 28s-4 show with jury or other treumstic event, the Medical Examinal must be notified at page.

Baitimore, Maryland 21215-0020

Bank

Physiciar/Medical Examiner þ Be Completed Medical Cartification: To

To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit P.O. Box 68760. Records, Division of Vital

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

2000

Matural

2 Accident

3 Suicide

29a. Certifier (Check only one)

29b, Stynature and

4 Homicide

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

S-18h MS 21861

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

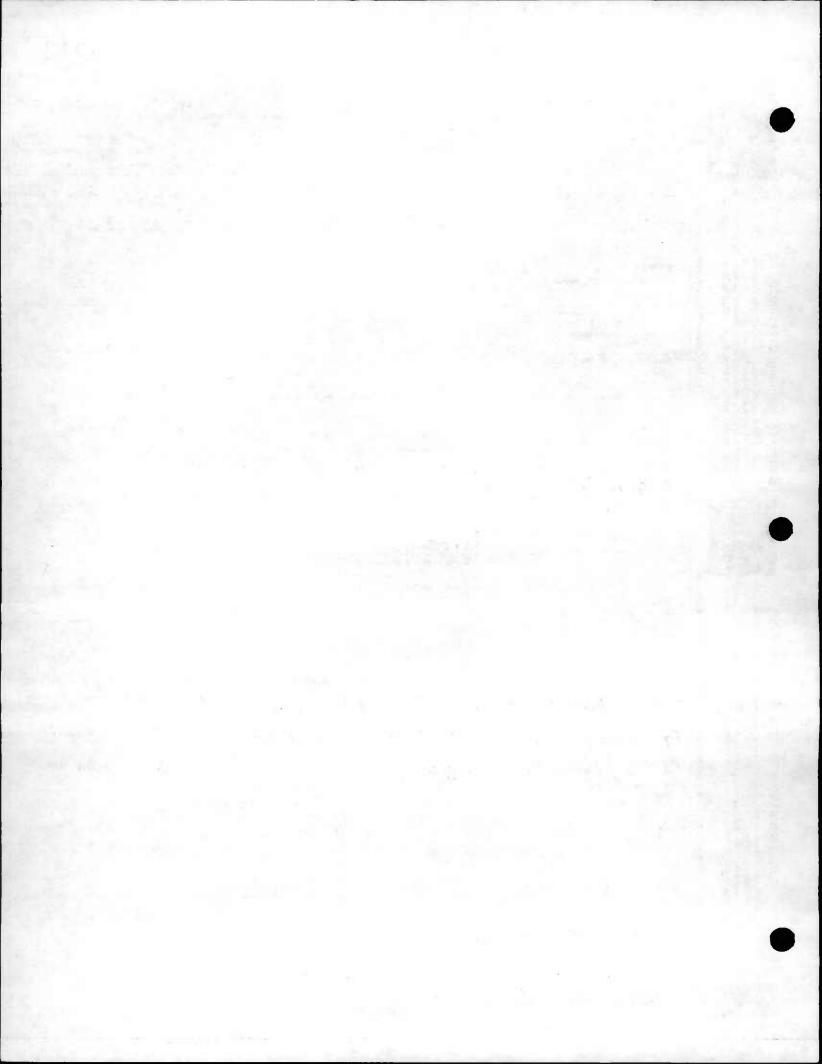
29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

1					Ce	ertificate o	f Death		R	eg. No.		-6 1 1 C-	
п	Physician	1. Decedant's Nama (First, Mid						2.	Date of Dear Month	th Day	Year	3. Tima of Death	
4	/Medical	Louise Blanche	Brown					I A		19, 200		12:00 Noon	
	Examiner	4a Facility Name (If not institut	tion, giva street and nu	mber)			4b. City, Tow	vn, or Local	ion of Death	4c. County	of Deeth		
		Chestertown Nu	rsing & Re	hab Cer	nter		Ch	nester	town	own Kent			
	Funeral Director	214-30-9216 1 <sup>DM</sup> 2XF		7. Aga (In yrs	65 Yrs.	Months Day		Min.	(Month, Day, Year) Country)			laca (State or Foraign try) eville, MD	
	P .	Usual Rasidance of Decedant  10a. Stata 10b. Cour		140-0	- T								
	show		ity	10c. C	ity, Town or L	ocation				10d. Inside City Limit			
	d 21215-0020 If it is within 72 hours after death with the Maryland Hygiene. If the Than "natural", or items 23s or 28s-f show but, the Wedcal Exeminer must be notified at some property of the Medical Exeminer must be notified at some please.	Maryland Ker	ıt		Che	stertown				_		1)X) Yas 2□ No	
		10e. Street and Number				10f. Zip Code			1	0g. Citizen of \		itry?	
		415 Morgnec Ro					21620				SA		
21215-0020	rat", or from	11. Marital Status  1 ☑ Navar Marriad 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Armed Forces?  1 ☐ Yas 2 ☑ Ni Yas, Giva Year or Dates:			J,S. 13.	Was Decedent of If Yes, specify Cu		in? (Specif , Puerto Ric	y Yas or No- an, etc.)		ca - Amaric ck, White, v: B1		
5-0	ed within 72 hours ygiene. wr than "netural", rt, the Medical Eas Completed by		ant's Education nast grada completed)	3 5 7 1	16a. Dece	edent's Usual Occ	upation	of working		16b. Kind of B	usiness/Inc	dustry	
21	ithin name	Elamantary/Secondary (0-12		1-4or 5+)	lifa.	e kind of work don DO NOT use reti	red)	or working					
	Con the	8			Dome:	stic Worl	T			Domest:		me	
Maryland	d oth	17. Fathar's Name (First, Middl	a, Last)				18. Mother	's Nama (F	irst, Middle, I	Maiden Sumen	10)		
Va Na	should and Men and Men arked	William Smith											
a	2 she and ls m	19a. Informant's Name/Ralatio	nship (Type, Print)		19b. Mail	ing Addrass (Stre	et and Number	r or Rural R	outa Number	, City or Town,	Stata, Zip	Code)	
	and 3	Blanch Taylor			5811	McMahn S	Street,	Phi1	ade1ph	ia, PA	1914	4	
ore	of He	20a. Mathod of Disposition			Place of Disp cematary, cre	osition (Nama of emetory or other p	lace)		Data	20c. Location -	City or To	wn, Stata	
Ĕ	Peges nant of I int: If Its	1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other		Stata		Cremation		HC 4/	21/2000	Ster	<i>j</i> ensvi	Lle, MD	
Baltimore,	pemiit. Peges 1 and 2 should be filed withir Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic event, tra Manca.  To Be Compl	21. Signature of Funeral Service		de, ib									
m	20 5 5 5	> Birk of	Helfah.			ellows, Hel							
		23a Perti. Entar the diseasa	or complications that o	aused the dee	th. Do not en	O Speer Ro	ad, Ches	stertow	n, Mary	land 2162	20	Approximete	
	Obversion	23a. Pert1. Entar the diseesa, shock, or heart feilura. Li	st only ona cause on e	ach line.	an. Do not or	101 010 111000 01 0	yang, suor es c	ATOREC OF TO	sapilatory of	ost,	1	Interval Between Onset end Death	
	Physician /Medical	Immediata Causa (Final diseasa or condition as UVOSepsis										8 days	
	Examiner	diseasa or condition rasulting in daath)	a	uro	seps	15				Sump			
				Dua to (	or as a conse	quence of):							
	executed on and rial-transit		b			500					i		
	and al-tra	Sequentially list conditions, if any, laading to immediata		Dua to (	or as a conse	quence of):					i		
68760,	cate be executed physicien and the bunial-transit cdical Examir	Causa. Enter Undarlying Cause (Disaase or injury	<b>c</b>								i		
387	ficate be physicients the bunch of the bunch	that Initiated evants resulting in daath) Last		Dua to (	or as a conse	quence of):					i		
×	ding pt se as t		d								i		
Box	at the deeth cerd by the attendir latached for use												
o	the the hed	Part II. Other significant condi	tions contributing to de	eath but not ras	sulting in the u	underlying cause (	given in Part I.		23b. Did tobacco usa contribu			the cause of death?	
Φ.	The law requires that the deeth certificate be executed ate has been signed by the attending physicien and page 2 should be datached for use as the burial-transit completed by Physician/Medical Examir	ASCUDE/ WILL	iple CVA/	Pariplion	al Vasc	Dol Du	TypoII		PECY	es 2 No	3 Prot	bably 4 Unknown	
Records,	uiras the signer of be d		11 0 11-	1 11	1-0	34	da		24a. Was a	n autonsv	24b. Wa	are autopsy findings	
Ö	The law require cate has been signage 2 should to Completed	Bleed 1	Multiple UT	I/Hx	GIR	domone	/ HT	(0	perform		ave	eilable prior to impletion of cause	
3e	has pe 2	1000 /4	D 10	T 11.							of	death?	
<u>e</u>		COPD / Cure	ouic Renal-	Lusuffi	concy				1 🗆 Ya	as 200 No	10	]Yas 2□ No	
Vital	Physician: The ribis certificate trail director, par.	25. Was casa rafarrad to medic axaminar?				10		of Death (C	check only on	a)			
of	S O D	1 ☐ Yas 2 No		Inpatient 2		UL 3LI DOV				ence 6 Oth		y)	
2	fler ther unar	27. Menner of Death 1 XNatural 5 ☐ Pano	ing 28a. Data	of Injury th, Day Year)	28b. Tima o	W	ury at ork?	280	I. Describe ho	w injury occur	red		
Sio	Attending or deeth.  ector: After by the funalification	2 Accidant invas	tigation			M 1	]Yas 2∏N	io					
Division	is after death. Is after death. Is Director: After led in by the funari Certification:	3 Suicide 6 Coul 4 Homicida data	mined 200. Place	of Injury - At h	nome, farm, st	reet, factory, offic	9	28f.	Location (St City or Town	treet and Numb n, Stata)	er or Rura	l Routa Number,	
Ω	tal or its after in led in Cert								211.0				
	in 24 hours he Funer pletely fill edical	29a. Cartifier 10 Certify (Check only 2 Medical	ing Physician: To that it Examiner: On that be	best of my kno	owledge, deat	th occurred at the	tima, date and	place, end	due to the ca	ause(s) end ma	anner es si	ated.	
	To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funaral Medical Certification;	one)	and man	ner stated.				. ocouried	o, and thrite, O	a.a and piece,	and dua (C	04430(3)	
	To the troop	29b. Signatura and title of curtif	iar O O	001		29c. Lice	nse number		2	9d. Data signe	d (Month,	Day, Year)	
		Mode	della	alls.		D50	0996			April 2	20. 20	200	
		30. Neme end addrass of perso	n who completed caus	e of death (Ite	m 23a) (Type,						- C - C		
		Neil Stoddard	100 Brown	Street.	Chest	ertown.	Marvla	nd 21	520				
	State	31. Date filed (Month, Day, Yea	10 A 32. R	egistrar's Sign		4							



	MS: #23 PART I  1. Decedent's Name (First, Mide		2. Dete of De Month	Reg. No. eath Dey Yeer		3. Time of Death							
ian ical	Abagail Krist	ine BENEDIC	Т				APRII		2000	4:27 AM			
iner	4e Facility Neme (If not instituti						or Location of Deet			ONI			
	WASHINGTON COUI 5. Social Security Number		Age (in yrs. les	t birthdev)	f Under 1 Yeer	HAGERS'			HINGT 9 Birtho				
	N/A			lonths Deys	Hours M		18,2000		elace (State or Foreign stry) Vland				
	Usual Residence of Decedent		10- 04- 7	Saura and anat									
5	MD Was	nington	Tuc. City, 1	own or Locat	stown				1	0d. Inside City Limits 1 Yes 2 □ No			
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	Whet Cour				
Ö	128 1/2 South	Locust Str	eet		21740			U.S.A		,			
ner than "natural", or heart, for the fact that the completed by Fur	11. Maritel Status  1 Never Merried 2 Ma 3 Widowed 4 Divorce	If Yes, Give	es? No	If Ye	s Decedent of Hes, specify Cub	dispente Origin? an, Mexicen, Pur Specify:	(Specify Yes or No erto Ricen, etc.)	Blac	e Americk, White,	etc.			
		nt's Education est grade completed)  College (1-4		(Give kin	NOT use retire	during most of w	vorking	16b. Kind of B	usiness/Ind	dustry			
De C	17. Fether's Neme (First, Middle	, Last)					leme (First, Middle		16)				
2	Bruce E. Bene	dict	Lisa N	Michele F	ayne								
	9e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, 2												
+	Bruce E. Benedict / Father 128 1/2 Locust St., Hagerstown, MD 21740  20e. Method of Disposition (Name of cemetery, cremetory or other place)  20b. Place of Disposition (Name of cemetery, cremetory or other place)												
	NOTE Suriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (		ate		ory or other ple Cemete		1122	5/6/2000 Hagerstown, MD					
-	21. Signeture of Funeral Service			22. N	ame and Addre	ess of Facility			,		_		
	Scatt Minnich Funeral Home												
	23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.  Approximation of the mode of dying, such as cardiac or respiratory errest, interval B												
	Immediate Cause (Final disease or condition resulting in death)		DEN UNE	XPECTEI	DEATH	IN INFA				Onset end Death			
ner			Due to (or a	s a conseque	ice oi).	7							
dicai Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	<b>5</b> b.	Due to (or e	s e conseque	nce of):	74	45.5						
Physician/Medica	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or es e consequence of):												
iciar	Pert II. Other significant condit	225 Did	23b. Did tobacco use contribute to the cause of genth										
by Phys	rath. One significant condu	to dear	II DUL FIOL FESCILII	ig in the unde	myrig couse gr	veri iri Perci.				bably 4 Unknow			
Completed	ALC: U							s an eutopsy ormed?	av	ere eutopsy findings eilable prior to mpletion of cause deeth?			
0							1 🖳	Yes 2□No	15	Yes 2□ No			
Be	25. Wes cese referred to medic examiner?				low		eath (Check only	one)					
10	1XX es 2 No 27. Manner of Deeth	Hospitel: 1 Inp		VOutpetient 3b. Time of	OLI DON		Home 5 Res			y)	_		
tion	1 Neturel 5 Pend	ing FOUND	Dey Year)	Injury UNKNOW	28c. Inju Wo 1□	rk? ]Yes 2⊠No		how injury occur	100				
Certification:	3 Suicide 6 Could	not be 28e Place of	-00 Injury - At home , etc. (Specify) FOUN	farm etropt	factory office	-R	UNKNOWN  281. Location (Street and Number of Rurel Route City or Town, State) 128-1/2 S.  ST. HAGERSTOWN, MD			ol Route Number S. LOCUST			
edical		ng Physician: To the be I Examiner: On the basi end menner	est of my knowle s of examination	dge, deeth od	curred et the ti		ice, end due to the	ceuse(s) end m	enner es s	teted.			
	29b. Signature and title of certific	er +		MM	29c. Licens	se number		29d. Date signe	d (Month,	Dey, Year)			
	XI.	www	1,1	(リ)	-71	.C.M.E.		MAY 1	, 200	0			
-													
	30. Name and address of perso	who completed cause of the complete of the com	tuner			treet. F	Baltimore	. Marvla	and 2	1201			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last)
WILLIAM M 2. Data of Death 3. Tima of Death BRITT **Physician** Month 4 20 2000 2228 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 5. Social Security Number 251 - 24 - 3573 If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-5-28 Sax 180 M 2□ F 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Hours 71 Yrs. Director SOUTH CAROLINA Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD. WORCESTER OCEAN PINES 1 ☐ Yas 2 ☐ No Director must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Q Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. filed within 72 hours after 1 Yas 2 No If Yas, Giva Year or Detas: 2N Married 1 Nevar Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: natural', or ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 Broker REAL ESTATE permit. Pages 1 and 2 should be field Department of Health and Mental Hygis Important: If Itam 27 is marked other 1 any injury or other traumatic event. It 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be 2 PAT MCKENZIE LARKIN F. BRITT 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) BRITT 6. PINES MD 2 20c. Location - City or Town, State ALMA BROOKSIDE RD. SPOUSE OCEAN 21811 20a. Mathed of Disposition 20b. Place of Disposition (Nema of cematary, crematory or othar place) Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 4-24 MEMORIAL PARK BERLIN, MD. SUNSET 21. Signatura of Funaral/Samue Licenses 22. Nama and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD 23a. Pert1/En/ar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner burial-transit certificate be executed Sequentially list conditions, if any, laading to immadieta cause. Entar Undarlying Cause (Disease or injury and Box 68760. ettending physician for use es the buria that initiated evants rasulting in daath) Last Due to (or as a consequence of): The law requires that the deeth Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by Yes 2 No 3 Probably 4 Unknown neuryxn à 8 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peed cate has 20 No 1 Yas 1 ∏ Yas 2 ∏ No certificate Division of Vital Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this certifica etely filled in by the funeral director; F Be 25. Was casa refarred to medical 26. Place of Death (Check only ona) axaminar? Hospital: 1 Inpatient axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27 Menner of Death Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Neturaf 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 ☐ Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, sfreet, factory, office building, atc. (Specify) 4 Homicide • Funeral Di To the Hosp within 24 hor To the Fune completely fi 29a. Cartifian 🖼 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end plece, end dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated. 29b. Signatura and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 2

Registrar

State

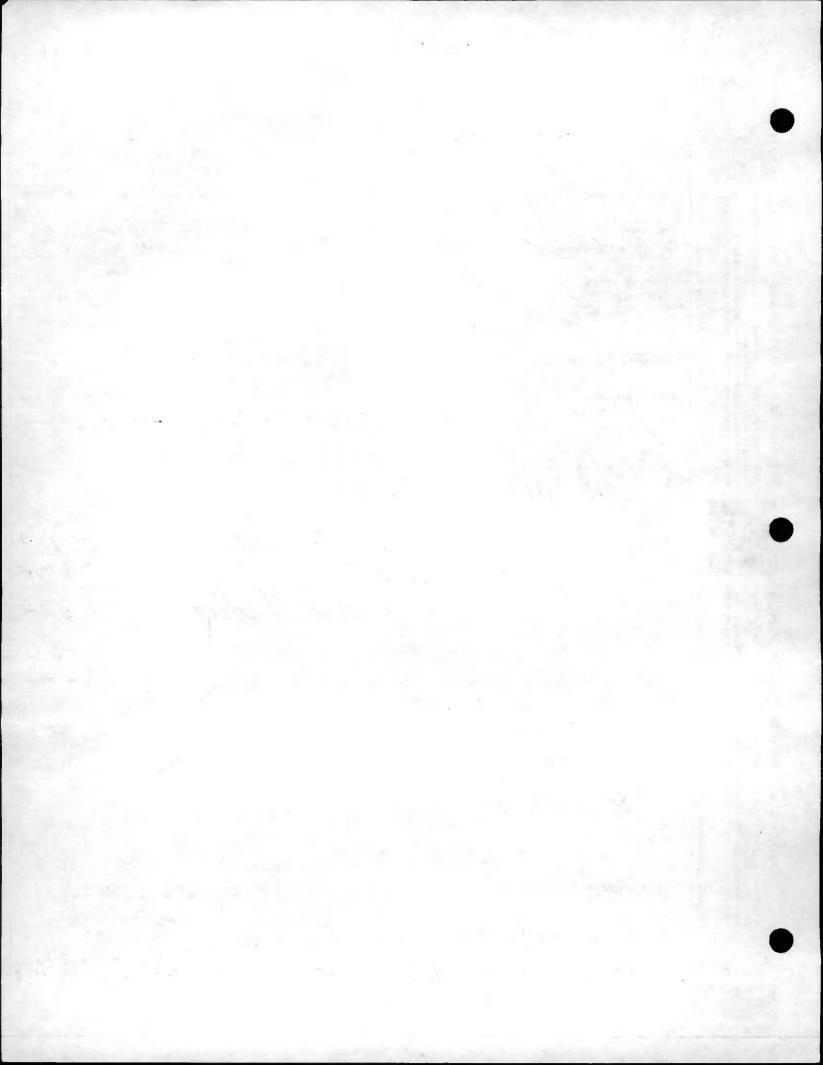
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APR 24

2000

Item 23a) (Type, Print)

Registraris Signatura



State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year WILLIAM FRANCIS CUTTER /Medical APRIL 20,2000 0145 A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND SACRED HEART HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) MAY 10 1927 Birthplaca (Stata or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) **Funeral** Days Hours 10XM 20 F Yrs. Director 22 6533 216 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-1 show hem 27 is marked other than "natural", or itema 23a or 28a-f show other trisumatic event, the Madical Expansion rival be notified at Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 21532 U.S. 66 W. MECHANIC STREET death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien Black, White, atc. 11. Merital Stetus 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiana. Important: If Item 27 is marked other than any injury or other traumatic event the Mental Health and Item Elementary/Secondary (0-12) College (1-4or 5+) COAL 6 MINER 17. Father's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) Be GEORGE PRINCETON CUTTER RHODA VICTORIA McLENZIE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) BARBARA CUTTER / WIFE 66 W. MECHANIC ST., FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 Crametion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 4/22/00 FROSTBURG, MD 21. Signature of Funeral Service Licens 22. Name and Address of Fecility SOWERS FUNERAL HOME, P.A. Dure 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Batween Onsat and Deeth **Physician** Immediate Ceuse (Final diseasa or condition resulting in daeth) /Medical Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediate causa. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest P.O. Box 68760. Physician/Medical Due to (or es a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy mellitis 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, I 25. Wes casa referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) Hospital: 1 Yas 2 No P 1 12 Inpatient 2 ER/Outpatient 3 DOA 27. Mennet of Deeth 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 5 andhy APRIL 20 2000 30. Nema end eddrass of person who completed ceuse of death (Item 23a) (Type, Print) Sandhir 48 MUS arn Dikander Terrace, Frostburg, ND 21532

**DHMH 16 Rav 6/95** 

State

Registrar

31. Deta filed (Month, Dey, Year)

APR 2 5 2000

Registrar's Signature

32

State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** April 27, 2000 MABEL VIRGINIA CRABLE 6:05 A.M. /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner EGLE NURSING HOME LONACONING ALLEGANY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year Birthplece (State or Foreign Country)
 MD 7. Age (In yrs. lest birthday) Funeral 1 M 2 M F Months Days Director 215-20-7489 89 October 04, 1910 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural, or items 23s or 28s-f ehow any fujury or other traumatic event, the Medical Examinat must be redified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **ALLEGANY** LONACONING 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 26 CHURCH STREET 21539 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No If Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify. δ 3 ₩ Widowed 4 Divorcad Yeer or Dates: WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) COOK **SCHOOL** 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be OROMA A. HARRISON IDA MAY FRYE ဥ 19a. Intormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) HELEN FOLK 64 WRIGHT STREET, FROSTBURG, MD 21532 DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State April 29, 4 ☐ Donetion 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 2000 FROSTBURG, MD 21. Signature of Funeral Servica Licansee 22. Name and Address of Fecility ames E McKenzee Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 23a. Pert<sup>1</sup>. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Congestive Heart Failure 2 years Examiner Due to (or as e consequence ot): Physician/Medical Examiner ed by the attending physician and datached for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Lest Division of Vital Records, P.O. Box 68760, year S Due to (or as e con 15 years enoscieros Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Pulmonary 2 No 3 ☐ Probably 4 ☐ Unknown Ibstructure 24b. Were eutopsy tindings eveileble prior to Completed 24e. Wes en eutopsy peeu completion of cause of death? certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, I 25. Was case reterred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated. 29a. Certifier Medical 29b. Signature end title of certitier 29d. Date signed (Month, Day, Yeer) 29c. License number J coul 28, 4 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 57 LACKSON LR MILES, JR M.D. ST. LONACONING 21539 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State APR 2 8 2000 Registrar

**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Tima of Death April 25, <sup>Day</sup> 2000 Physician Charles Franklin Clark, Sr. 2:10 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21219 Chesapeake Avenue (Residence) Rock Hall Kent If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 13, 1932 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) Funeral 1∭M 2□ F 67 Yrs. 220-28-1083 Director Rock Hall, Maryland Usual Residence of Decedent the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 □ No Director In and Menial Hyglene. 7 Is marked other than "natural", or Items 23s or 28s-f traumetic event, the Medical Examicer must be notifie Maryland Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21219 Chesapeake Avenue 21661 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or ther any injury or other traumetic event, the Medical Exeminar 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surname) Owen Clark Elizabeth Ashley 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Ruth Ashley Clark PO Box 52, Rock Hall, Maryland 21661 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) Wesley Chapel Cemetery 4/28/2000 Rock Hall, MD 21. Signature of Funeral Se 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast.

Approximate and the death. Do not enter the mode of dying, such as cardiac or raspiratory errast.

Approximate 23a, Part1, Ente shock, or h **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) prostade Examiner Physician/Medical Examiner physicien end s the burief-transit or Attending Physicien: The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequence of): Due to (or as a consequence of) for use es should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 2 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? his certificate h 1 Yas 2 No 1 Yas 2 XNo 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 100 After thi funerel 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 5 ☐ Pending investigation Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stafa) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one)

Records, Division of Vital a 24 hours effer deeth.

• Funeral Director: After the function of the functio Hospital To the Hosp within 24 hor To the Fune completely fl

3altimore, Maryland 21215-0020

P.O. Box 68760.

State Registrar 29b. Signature and title of certifie

30. Name and address of person who complete to 31. Data filed (Month, Day, Year) 32. Registrar's Signatura APR 2 5 2000

Chestertown maryland

29c. License number

0005178

DR Andrew

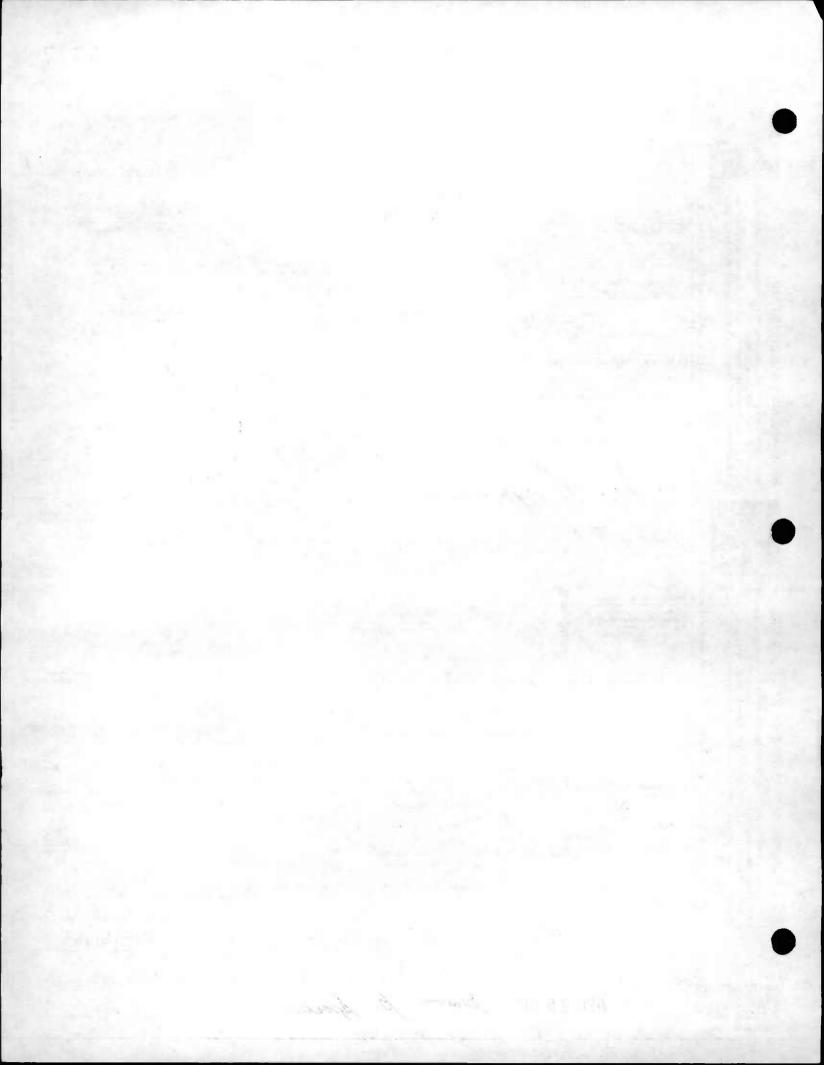
29d. Date signed (Month, Day, Year)

S. Ferguson

2000

**DHMH 16 Rev 6/95** 

use of death (Item 23a) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Year **Physician** Bernice Esham Cathell April 22 2000 0526 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 B€F 101 Yrs. Director 220-16-9553 Feb. 19,1899 Maryland Usuai Residenca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 NYes 2 No Md. Worcester Berlin Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? I Meadow St. 21811 US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Maritai Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: white ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 11 School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Joseph Henry Esham Jennie Powell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Moore 319 S. Main St., Berlin, Md. 21811 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. John's Cemetery 4-25-2000 Fruitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Savice Licenses 22. Name end Address of Fecility The Burbage Funeral Home 108 William St., Berlin, Md. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervel Between Onset and Death se, or complications that caused the death. Do not enter List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Fadure Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the ceuee of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown P 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy 2 12 No 1 Tyes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medicai 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 Medical Exeminer: On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical

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death with the Maryland

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this certificate has ral director, page 2

funeral

After

ofter death

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Registrar

30. Name end eddress of person

29b. Signature and little of codillo

29c. License number

29d. Date signed (Month, Day, Year) 26

who completed cause of deeth (Item 23e) (Type, Print) Licholds lee Highway 45

32. Registrar's Signature

L. Fall (w

Investigation

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Dev Hear Monroe 2311 pri 2000 4e Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Carroll County General Hospital Westminster Carrol1 If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Deys 1 ₩ M 2 □ F Months Hours 85 Yrs. 219-36-0020 Maryland Nov. 4 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Maryland Carroll Westminster 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4122 Ridge Road 21157 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus 1 ☐ Never Married 21 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorcad 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th farmer & Construction foreman self-employed 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Upton Burgess Condon Amelia Barnes 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lurena Condon 4122 Ridge Road Westminster, MD 21157 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Taylorsville Ch. Cemetery 4/21/2000 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville, MD of Funeral Service Licansee 22, Neme end Address of Fecility Burrier-Queen Funeral Directors, P.A. amu veu 1212 W. Old Liberty Road Winfield, MD 21784 enter the disease, or complications that cause he deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one cause on each second sec Approximete Intervel Between Onset end Death 234 Pert1 Immediate Ceuse (Final diseese or condition resulting in death) Due to (or es e consequence of): 4days poxemia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of) 13 days eumonitis Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy 1 PY Vas 2 No 1 Type 2 PM 25. Wes case referred to medical 26. Plece of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28PNo 1 Yes 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manne of Death Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

The law requires that the deeth certificete be executed After this certificate hes been signed by the ettending physician end funeral director, page 2 should be deteched for use as the buriel-tran Division of Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun-

Physician/Medical þ Completed Be 10 Certification:

Medical

Examiner

**Physician** 

**Funeral** 

Director

ham 27 is merked other than "natural", or items 23s or 25s-f sho other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be tiled within 72 hours after Obeptiment of Health and Mental Hygiene. Important: if them 37 is merked other than "natural; or the any injury or other tranmetic event, the Medical Examina

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

with the Maryland

/Medical

Directo

Funeral

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Completed

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6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted. (Check only 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s)

29b. Signeture and titl

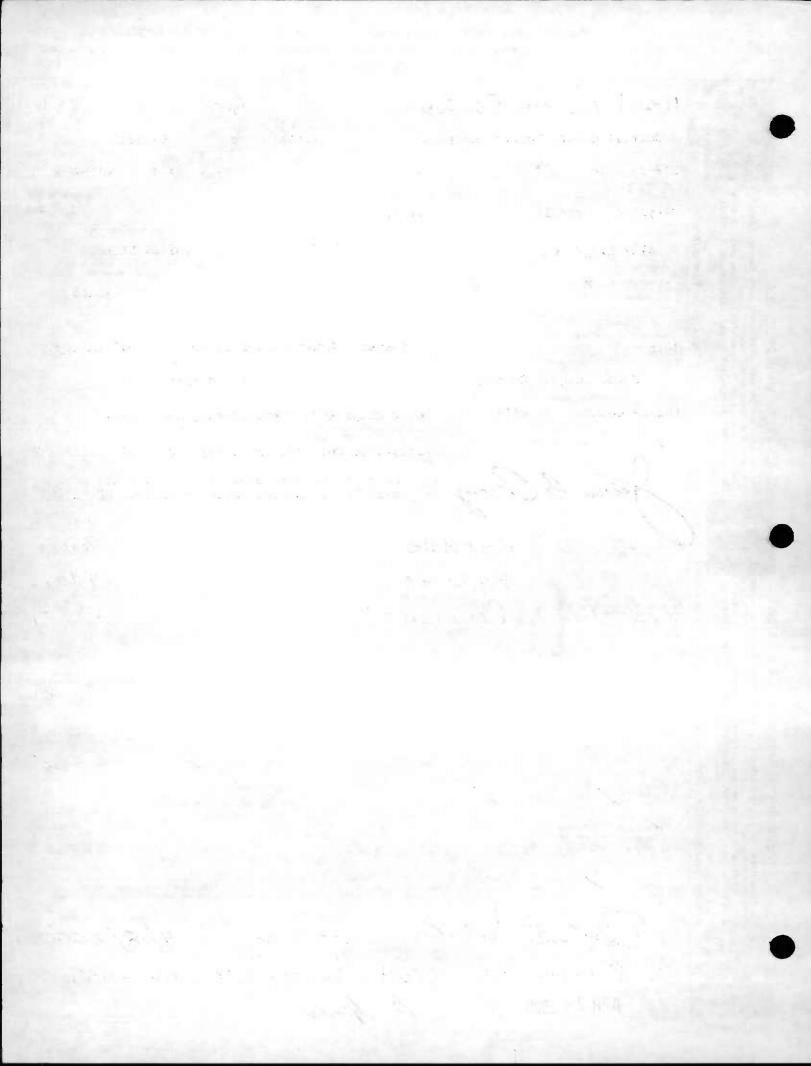
29c. License number D39296 29d. Date signed (Monthy Dey, Yeer)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ckett MD

200 memorial Ave. vestminster, MD

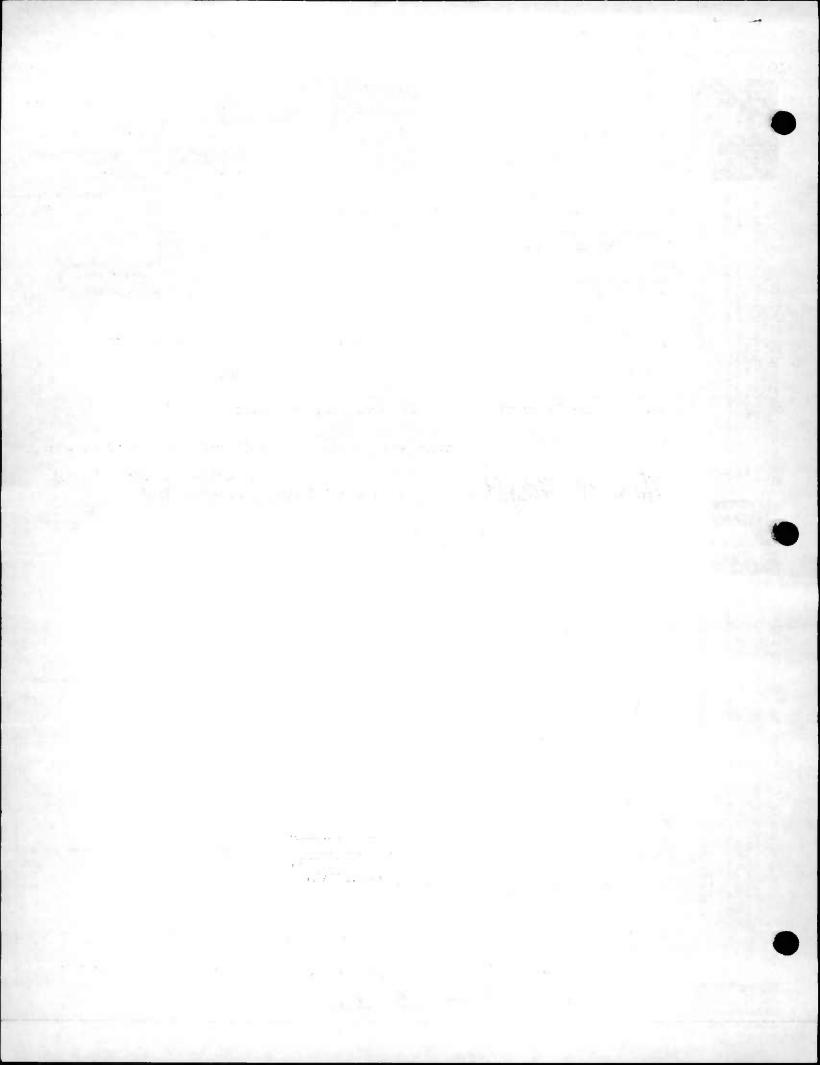
State Registrar 31. Date filed (Month, Day, Year) APR 24

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene 0

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			P.O. Box 195 Sykesville, Md 21784															
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2	death ctor: y the	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not	be on Dies	e of Injun	/ - At home, far	m stre			)Yes 2 □	INO	28f. Locat	ion (Stree	et end Numb	er or Rure	l Route Nun	n <i>ber</i> .
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	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this cartificate has complately filled in by the funeral director, page 2	edical (	29a. Certifier (Check only	Certifying P	hysicien: To the	e best of	my knowledge,	deeth	occurred e	et the ti	me, dete er	d place,	end due to	the ceus	ceuse(s) end menner es steted.			
	the H hin 24 the F nplate	Medi	one)		end mei	nner state	d.	Inetion end/or investigation, in my opinion, deeth occur					ed et me t					5)
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			Ho -	ar Fong	completed cau	Tw-			Non	th	Dr	C	lund	via	April	210	45	
	Sta	ate	31. Date filed (Mo	onth, Day, Year)	32. 1	Redistrar's	s Signature											
	Regist	rar		APR 202	2000	Pene	va ,	G	Se	och	2							



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Year 0700 24, 2000 4c. County of Death HENRY CORDES APRIL OHN 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) MARCH 20 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 108'M 2□ F Yrs. 1911 NEW 097-09-1275 YORK Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No VIRGINIA ACCOMACK CHINCOTERGUE 10e. Street and Number 10g. Citizen of What Country? 7161 BUNTING 23336 USA ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 1979s 2 D No If Yes, Give 29 MAR 1944 Year or Dates; MAR 1944 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LONG SHOREMAN / DOCK BOSS SHIPPING 12 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HERMAN SOPHIE CORDES HAUKUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILL RD 353 STATEN ISL. NEW YORK 10306 JOHN CORDES SON 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORIUM 25APRZOO CHINCOTENGUE VA 22. Name and Address of Facility Fox & HOLSTON FUNERAL HOME 5049 CHICKEN CITY RD. CHINCOTEAGUE, UR. 21. Signature of Funeral Service Licensee 5049 CHICKEN CITY 23336 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a cons Ove that initiated events resulting in death) Last NO V Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy WI 200 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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Pages 1 and 2 should be fill timent of Health and Mentel H lant: If item 27 le marked oth

Department of H Important: If iten eny injury or ott pace.

**Physician** /Medical

Maryiand

Baltimore,

097-09-1275

Funeral

Completed by

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cate has been signed by page 2 should be detact certificate this

Physician/Medical Examiner Be Completed by Medical Certification: To

Division of Vital Attending Physicien: after death. To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the

> State Registrar

27. Manner of Death 5 Pending investigation 2 Accident 3 Suicide

29b. Signature and title of certified

29a. Certifier (Check only one)

6 Could not be determined 4 Homicide

28a. Dete of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Location (Street and Number or Rurel Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

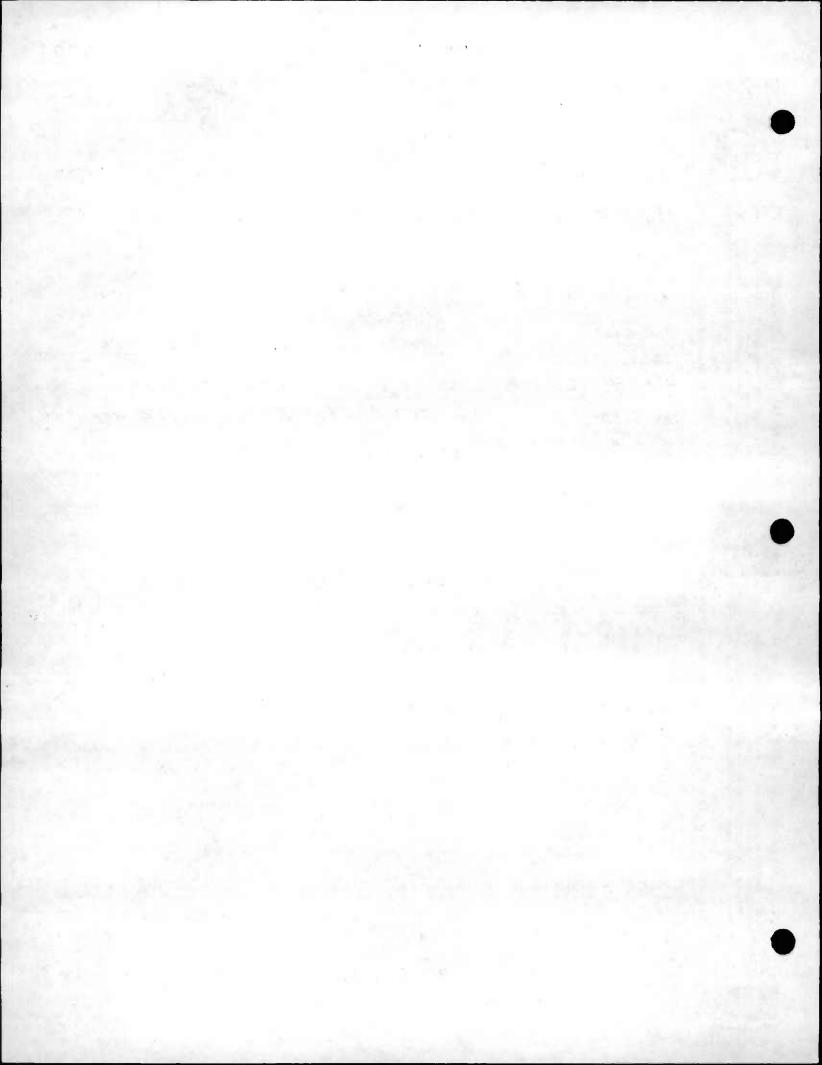
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASMA, AL-ITAMIO, 12137

31. Date filed (Month, Day, Year) APR 26

32. Registrar's Signature

29c. License number

**DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death AMEND ITEM: #25 PER G783 5-24-00 WR. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yeer **Physician** 8:15 PM April 12, 2000 John Walter Cooper /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Mary's 18622 Three Notch Road Dameron If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) If Under 24 Hrs Birthplece (Stete or Foreign Country) **Funeral** Deys 1**∑**M 2□ F 212-62-1349 Vre Director 44 Mar. 31,1956 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland St. Mary's Dameron the 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? with 18622 Three Notch Road 20628 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritel Status pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Haelth and Mantai Hygiana. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 □ Never Merried 2 □ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance 12 Insurance Agent 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Margaret Bertille Norris Phillip Roy Cooper, Sr. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) P.O. Box 336, St. Inigoes, MD 20684 Phillip R. Cooper, Jr. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Charlotte Hall, MD 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Brinsfield-Echols<sub>Cematory</sub>4/16/00 4 Donetion 5 Other (Specify) 20622 21. Signature Furneral Service Localized Brinsfield Funeral Home, P.A.

Edward N. Brinsfield, Jr. M00052 Leonardtown, Maryland 20650-0279 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Heart Failure /Medical Immediate Cause (Finel estive diseese or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner certificata be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequenca of) physician end Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Lest the Due to (or as e consequence of) USB BSU ed by the e 23b. Did tobacco use contribute to the causa of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed t þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en autopsy peed performed? pega 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No. cartificata Hospital or Attending Physician: director, Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 KResidenca 6 Other (Specify) OL 1 Yes 2€ No this funeral 28c. Injury et Work? 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Natural after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 29a. Certifier 1🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edicai completaly (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stelled. To the Vithin 2 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D33470 30. Name and address of person who go ted cause of deeth (Item 23e) (Type, Print) Bhasker A. Jhaweri, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

State Registrar 31. Dete filed (Month, Day, Year) 2000 32. Registrar's Signeture

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			Certi	ficate (	of Death		Reg. No.	1 -7			
Physicia		Decedent's Name (First, Middle, Last)							Tima of Death		
/Medic	al CIMEL.	DASHIELL	•			APRIL	11		1510		
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	5. Social Security Number 6. S	Sax 7. Aga (In yrs. Id	ast hirthday)	f Under 1 Y	ear If Under 24 Hrs	R Date of Bir					
Funeral Director		□M 2 <b>K</b> F 5				Month, De	-1941	M.B.	(State of Foreign		
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020 urs e	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,\$ Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Yaar or Datas:				pecify Yes or No to Rican, etc.)	ncify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: BLACK				
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THE STATE	6	Due to (or		1	-						
uted	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. deluted	1		yopathy			DAL	on known		
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To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the **Medical Certifi** State

Jon Falen MD 31. Data filed (Month, Day, Year)
APR 2 0 2000

29a. Certifier (Check only one)

MD

29c. License number 047353

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

2000

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

900 Caton Avenue

Baltmore, Maryland 21229

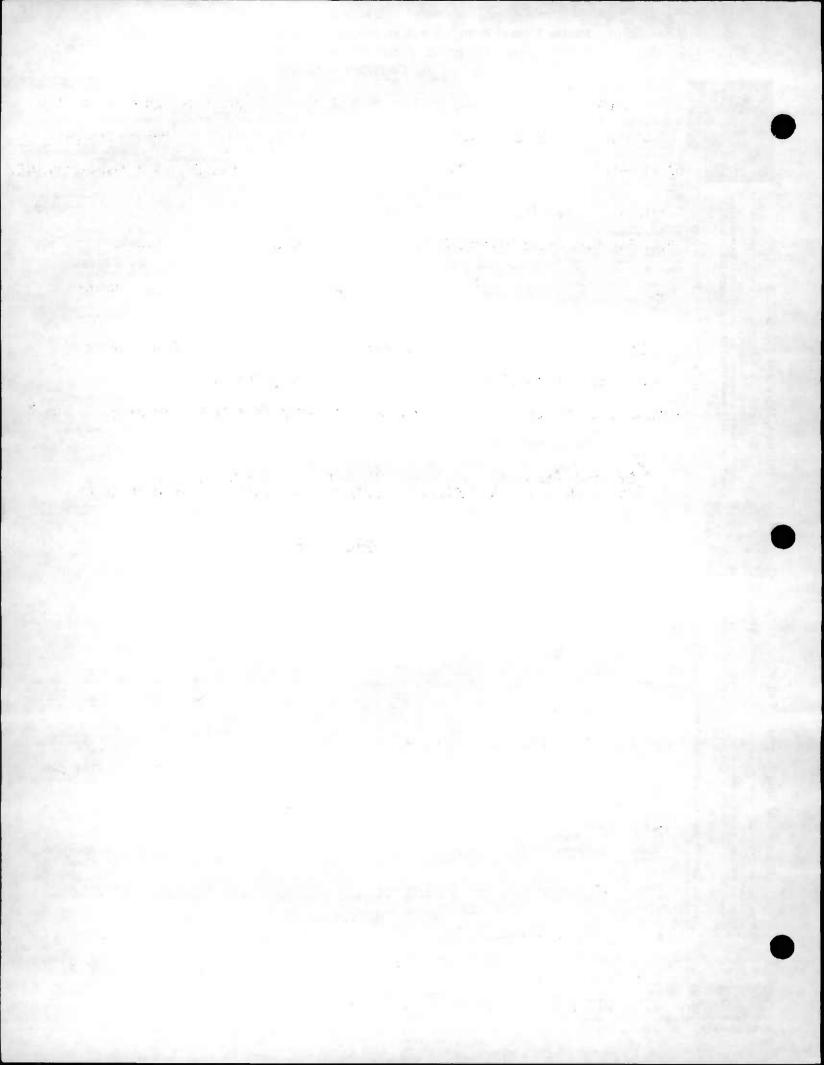
Registrar **DHMH 16 Rev 6/95** 

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State of Maryland / Department of Health and Mental Hygien 14721

DHN P. KNISLEY M01164 P.O. Box 156, Waldorf, Maryland 20604  23e. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervel Between Onset and Death    Physician / Medical Examiner							Cert	ificate of	Death	F	leg. No.		P / C= TY		
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30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)  Stephanie Trifos/10 MD 7500 Greenway Centra Drive Greenbalt Pro  State 31. Determined (Month, Day, Year)  32. Register's Signature		Hospita 24 hours Funeral letely filler	dical	(Check only 2 Medical Exem	Iner: On the basis of	examinetion	edge, deeth on and/or inve	occurred et the tinestigation, in my co	me, date end piece, opinion, death occur	end due to the red et the time,	cause(s) end me date end placa,	enner es s end due t	iteted. o the ceuse(s)		
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State 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture				30. Name end eddress of person who	completed cause of d	eeth (Item 23		rint)	enual Cen	to Dr	ive Gree	entre	I+ /9 20772		
		Sta	te	31. Dete filed (Month, Day, Year)	32. Registre	er's Signetur	-	las	1.1	, , ,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000 Physician Blanca Reynolds de Montes April 14, 9:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6910 Deer Valley Road Highland Howard If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (\$Country)
August 26, 1918 Bolivia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 27F Months Deys Hours Min Vrs Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1K Yes 2 No Directo Bolivia La Paz 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Edif Amazones Ave Funeral Arce <u>Bolivia</u> 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indien. 11. Marital Status Black, White, etc. 1⊠Yes 2□No Specify: Bolivian 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: à 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 80 2 Luis Reynolds Noemi Eguia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elena Montes Lawless /Daughter 6910 Deer Valley Road, Highland, Maryland 20777 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete April 16 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 2000 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, inc., 755/ Wisconsin Avenue 21. Signature of Funeral Service Licens Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary arrest 1 minute Due to (or es a consequence of): Examiner Advanced Endometrial Cancer 8 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): lan/Medical Due to (or es a consequence of): Physici Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of

Physician /Medical Examiner

Funeral

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"natural", or itema 23a or edical Examiner must be.

e filed within 72 hours after di Il Hygiene. other then "netural", or hem vent, the Medical Exampler.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if hem 27 is marked oth any Injury or other treumstic event abbs.

Baltimore, Maryland 21215-0020

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Certification:

funeral After

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Division of Vital

if or Attending after death.

To the Hospital or a within 24 hours after To the Funeral Direc completely filled in b

28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

(Check only 29b. Signature and fittle of certifier bry h Danet Lu

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

D39190

April 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3418 Olandwood Court #111, Olney, Maryland 20832 Joseph Garrett Reilly, M.D.,

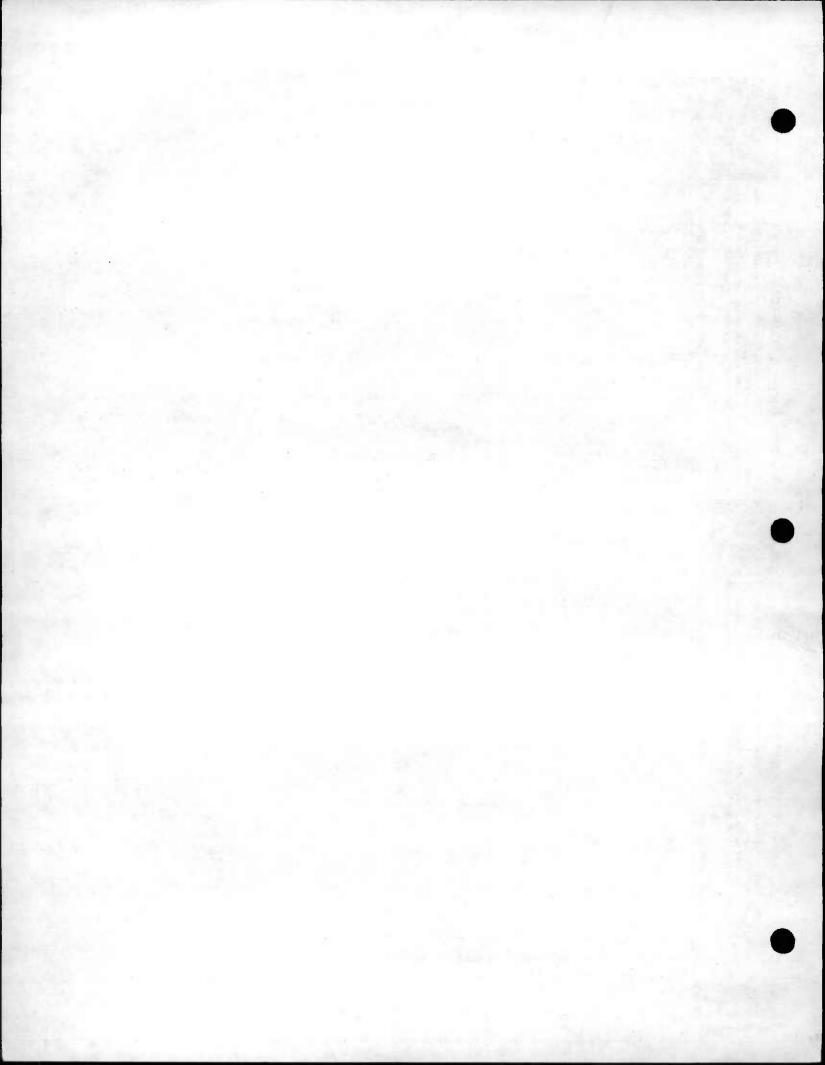
31. Date filed (Month, Day, Year) State

Registrar

29a. Certifier

2000 **APR 19** 

32. Registrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** THELMA ELIZABETH EICHNER 2000 APRIL 15 12:15 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HEARTFIELDS OF FREDERICK FREDERICK FREDERICK If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days 1□M 2/□F 90 214-07-6239 Yrs. Director JUNE 28 1909 MARYLAND Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MYes 2 No Director CUMBERLAND MARYLAND ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1100 FREDERICK STREET 21502 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Stetus permit. Pegas 1 and 2 should be filed within 72 hours effer c Department of Haalth and Mental hygiene. Important: if flem 27 Is marked other than "natural", or then any Injury or other traumatic event, the Marchal Evant Black, White, etc. 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 CELENASE CORP OF AMERICA SILK/MANUF. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be JOHN P. MILLER SOPHIA PERSCH 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ADAMS'FOWN, MARYLAND 21710 te 20c. Location - City or Town, Stete DAUGHTER REGINA BROWN 1432 PLEASANT VIEW ROAD 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date ↑ Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) HILLCREST CEMETERY APRIL 18 2000 CUMBERLAND MARYLAND 21. Signature of Funerel Service Lice 22. Neme and Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. nell 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest. ARYLAND shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical years -0100 Cancer Examiner Due to (or as a consequence of): Physician/Medical Examiner metastasis 4 mon attending physicien and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequence of) Box 68760. thet initieted events resulting in death) Last Due to (or es e consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown signed b Dementia Records, ð 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed page 2 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes cartificate Division of Vitai or Attending Physician: director, 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Aftar 1 Naturel 2 Accident 5 Pending To the Hospital or Attending within 24 hours aftar deeth. To the Funeral Director: Afti complately filled in by the fun 1 ☐ Yes 2 ☐ No investigetion 6 Could not be 3 Suicíde 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Two certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) and manner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dev. Year)

Registrar

mus

31. Date filed (Month, Dey, Year) APR 2 0 2000 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR HIREN SHAH 170 THOMAS JOHNSON DRIVE SUITE100 FREDERICK MARYLAND

APRIL 20, 2000

990 0 9 094

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Tima of Death Month Yaar **Physician** JAMES HUBERT ELRICK APRIL 27 2000 1:03 A.M. · /Medical 4a Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10103 SAND SPRING ROAD, NW FROSTBURG ALLEGANY 6. Sax 1X M 2□ F If Undar 1 Year If Under 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Deys Months Yrs. 85 216 09 4408 AUG 9 1914 MARYLAND Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 10103 SAND SPRING ROAD, NW 21532 U.S. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 🕅 No If Yes, Give Yaar or Dates: 1 Never Marriad 2 Marriad 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Spacify only highast grada complated) 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 SPINNING DEPARTMENT CELANESE 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be JOSEPH W. ELRICK AGNES THOMPSON 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 110 S. BROADWAY, FROSTBURG, MD 21532 JOSEPHINE COBURN/ DAUGHTER 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 27 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) THE CUMBERLAND CREMATORY 4/28/00 CUMBERLAND, MD upature of Funaral Sarvice Licensas 22. Nama and Addrass of Fecility SOWERS FUNERAL HOME, P.A. lasa, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, ra. List only one cause on each line. 23a. Part1. Entar tha diseas shock, or heart failura. Approximate Intarval Batween Onsaf and Death Immediate Cause (Final diseese or condition rasulting in death) 10 Yours Due to (or as e consequence of): Examiner Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in daath) Last Due to (or es a consequance of): Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? Melletos 12 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings eveileble prior to complation of ceusa of death? Completed 24a. Was an autopsy 1□Yes 2 No 1 Yas 2 No 25. Was casa referred to medical Be 26. Pieca of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Spacify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mennar of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Numbar or Rurel Route Numbar, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) end manner stated. 29a. Cartifiar Medical (Check only one)

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies completely filled in by the funeral director, to

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show simplicity or other traumatic event, the Medical Evaninar must be notified at 00.08.

Physician /Medical

Examiner

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signed by the a

s certificate has t director, paga 2 s

altimore, Maryland 21215-0020

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Registrar

0 31. Data filad (Month, Day, Yaar) State

29b. Signature end fitta of mortific

30. Nama and addrass of persoff who complated causa of death (Itam 23a) (Type, Print) SUNIL K. GÜPTA, M.D., 625 KENT AVE., CUMBERLAND, MD 21502

APR 2 8 2000

32. Ragistrar's Signatura

29c. Licansa number

00033280

29d. Dete signed (Month. Day, Year)

27

2000

00-2342-027 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ELIZABETH FRIESLAND State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, 27, 28A-F Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Elizabeth Rose Michelle Friesland APRIL 27 2000 1037 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 0 None NC Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1K Yes 2 No Director MD Ellicott City 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code Ct USA 8233 Tall Trees 21043 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Status Bleck, White, etc. hours aftar 1 Yes 2 DN6
If Yes, Give
Year or Detes: Never Married 2 Married 3altimore, Maryland 21215-0020 White 1 ☐ Yes 2 ☒ № Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natu any injury or other traumatic avent 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) n/a n/a n/a 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Terry Lee Allen 2 Virginia Mathis 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8233 Tall Trees Ct Ellicott City, MD21043 Virginia Friesland/mother 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a Method of Disposition Dete 20c. Location - City or Town, State 1 ⊠ Buriel 2 □ Cremation 3 □ Removel from State 4/29 Liberty Church Cem 4 ☐ Donetion 5 ☐ Other (Specify) Westminster, MD of Funeral Service Licensee 22. Name and Address of Fecility
Pritts Funeral Home and Chapel Washington Rd Westminster. MD 21157 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shoot, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** SUDDEN UNEXPECTED DEATH IN INFANCY /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of)

Physician/Medical signed by t by Completed Be 2 Certification:

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To the Hospital within 24 hours a To the Funeral C

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Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Pert fl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1/2 Yes 2 🗆 No 1/K Yes 2□ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 □XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Deeth

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) FOUND: 28b. Time of Injury A 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 9:15 1 Yes 2 No UNKNOWN 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 8233 TALL TREES CT

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND AT HOME 4 Homicide ELLICOTT CITY, MARYLAND 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10 enns 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

hute mo

111 Penn Street, Baltimore, Maryland 21201

APRIL

28,2000

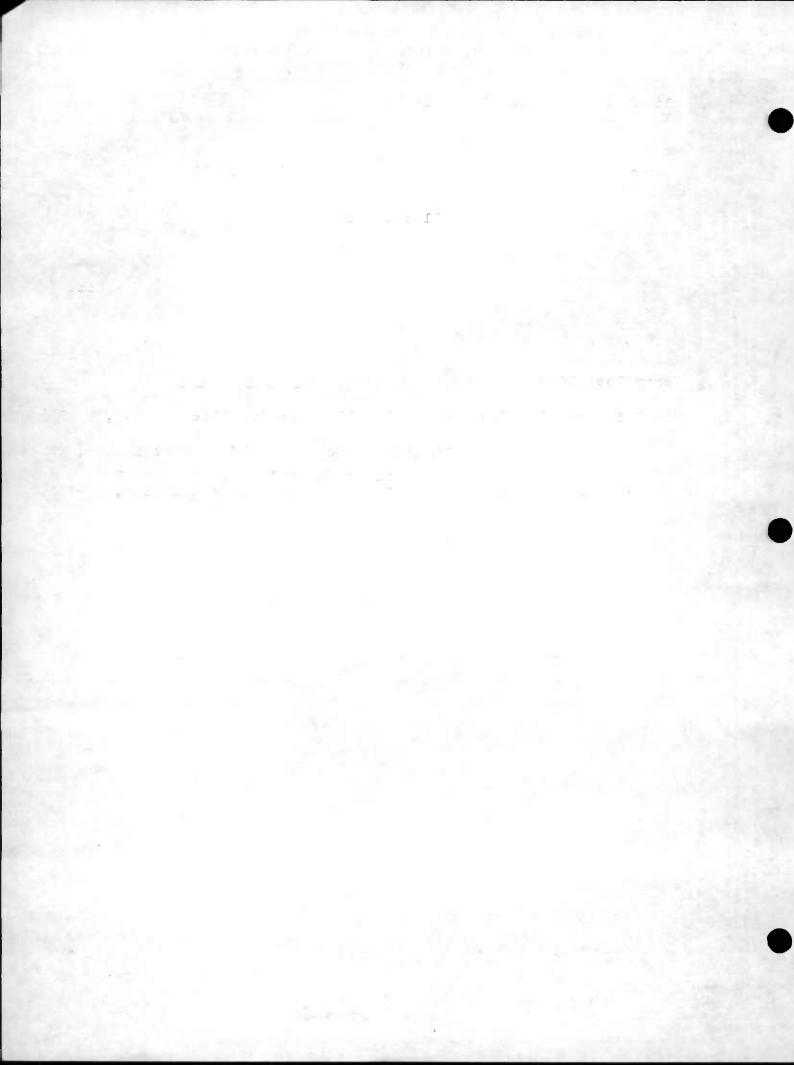
State Registrar

Denni 31. Date filed (Month, Day, Year) 32. Registrer's Signeture 1 armera

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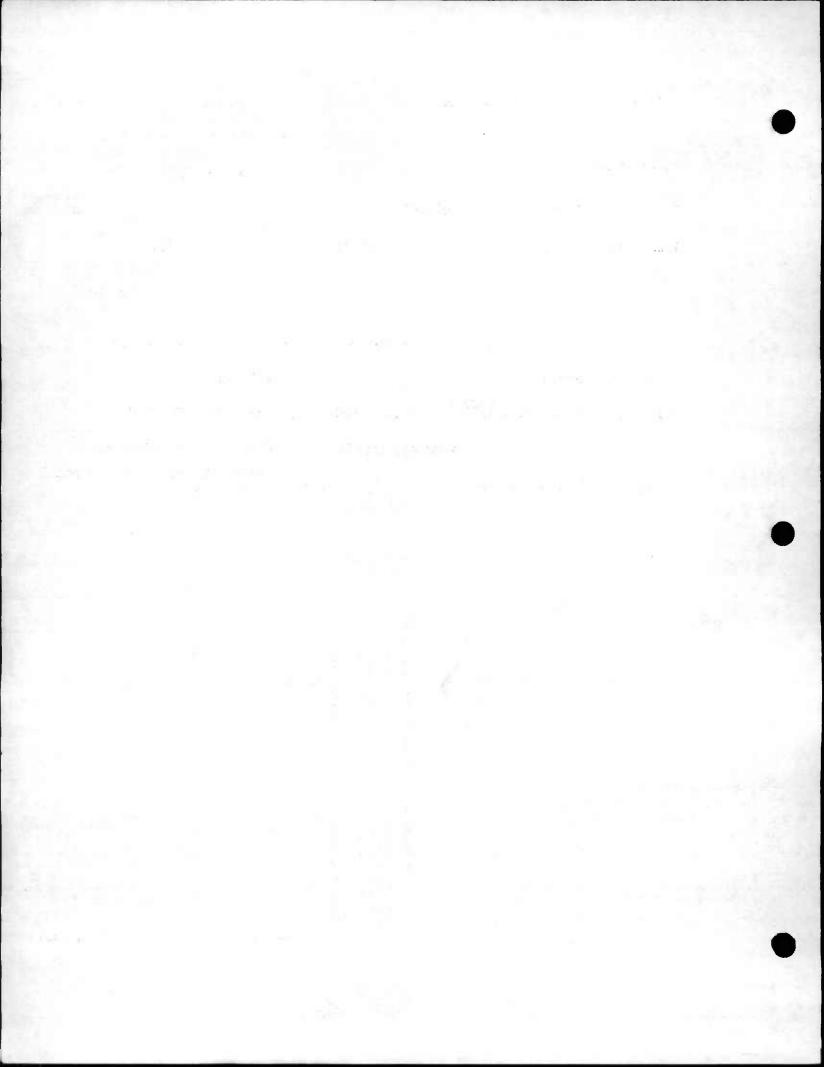
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth 3. Time of Death APRIL **Physician** Margaret 4:15 pm turman 2000 18 /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FAIRHAVEN SYKESVILLE CARROLL if Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 TF Months 096-18-9363 85 Director Dec 8 NY Usual Residence of Decedent deeth with the Meryland 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Merylan Depertment of Heelih and Mentel Hygiens. Important: If them 271s merked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 10d. Inside City Limits Md Carroll Sykesville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7200 Third Avenue 21784 USA Funerai 13. Was Decadent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Rece - American Indian, Bieck, White, etc. 1 Never Married 2 Married Yes 2 No f Yes, Give Baltimore, Maryland 21215-0020 1□ Yes 2No Specify: Specify: white þ 3 Widowed 4 Divorced Year or Detes: Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) economics teacher education 4 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Charles E. Furman Elinor Crowly ပ 19e. Informent's Neme/Relationship (Type, Print) (careqiver)9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Ave., Sykesville, Md 21784 Fairhaven Medical Records 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Marial 2 ☐ Cremetion 3 Nemovel from Stete 4+26-00 Canandaigua, NY Woodlawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licensee Paige Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Final diseese or condition resulting in death) /Medical **Examiner** Examiner The lew requires that the death certificete be executed ettending physician end for use es the buriel-trans Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequenca of): been signed by the should be deteched Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? certificate has ballinector, page 2 s 1□ Yes 2⊠No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: director, Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 2 After this 28a. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending efter death. 1 Yes 2 No Investigation 2 Accident 3 Sulcide 6 Could not be determined Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homlcide 24 hours To the Hospl within 24 hou To the Funer completely fil edicai 29a. Certifier 🖾 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) APRIL 15274 2000 n estine 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Ernestine Wright MD 7200 Third Ave., Sykesville, Md 21784 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State APR 20 Registrar 2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		Certificate	of Death	Reg. No.								
	Decedent's Neme (First, Middle, Last)		2.	Dete of Deeth Month Dev	3. Time of Death							
Physician /Modical	ELEANOR LEE GREEN				4 2000 7:30 AM							
/Medical Examiner	4e Fecility Neme (If not institution, give street and number)		4b. City, Town, or Locati		County of Deeth							
<b>L</b> xammer	Sacred Heart Hospital		Cumberl	and	Allegany							
Funeral		(In yrs. last birthday) If Under 1 Y		Dete of Birth (Month, Dey, Year)	9. Birthplace (State or Foreig Country)							
Director	234-42-7610	71 Yrs. Months De	eys Hours Min.	une 14,19	28 West Virgini							
	Usual Residence of Decedent											
72 hours efter death with the Merylend natural, or terms 23s or 28s-t show ficel Examiner must be notified at sted by Funeral Director	10a. Stete 10b. County	10c. City, Town or Location			10d. Inside City Limit							
Mer To	WV Mineral	Keyser			1 🙀 Yes 2 🗆 N							
urs effer death with the Meryler al', or items 23a or 28a-f show Examinar must be notified at by Funeral Director	10e. Street and Number	10f. Zip Co	de	10g. Cit	izen of Whet Country?							
	1465 Lynmar Street	2	6726		USA							
r Hems 23sh	11. Merital Status 12. Wes Decedent E		of Hispanic Origin? (Specify Cuban, Mexicen, Puerto Rice	Yes or No-	14. Race - American Indian,							
F. F.	Armed Forces?  1 Never Merried 2 Merried 1 Yes 2 N N		Cuban, Mexicen, Puerto Rici	an, etc.)	Black, White, etc.							
by by	3 XWidowed 4 □ Divorced If Yes, Give Year or Detes:	1 □ Yes 2 📆	No Specify:	Specify: White								
'natural', idicel Ex	15. Decedent's Education	16a. Decedent's Usuel O	ccupation	16b. Ki	ind of Business/Industry							
	(Specify only highest grede completed)	(Give kind of work d	one during most of working		The of Double of the Control of the							
then the	Elementery/Secondery (0-12) College (1-4or 5-	Homema			О П							
other than sent, trail	17. Fether's Neme (First, Middle, Last)	пошеща	18. Mother's Neme (F	iret Middle Maiden	Own Home							
- 0 2 3												
Mentel Mertel	Ernest H. Smith			Moreland								
pue e	19a. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (St	reet end Number or Rurel R	oute Number, City o	ir Town, State, Zip Code)							
Heelth em 27 i	Melvin D. Green/Son	HC 84, Box			5726							
of Heel	20e. Method of Disposition  1 Dr Burial 2 Cremetion 3 Removel from State	20b. Plece of Disposition (Name of cemetery, cremetory or other	- minoral		ocation - City or Town, Stete							
nent of I int: If Ita iry or o	4 Donetion 5 Other (Specify)	Duling Cemetery	APT. 20	i1 27 000	Keyser, WV							
P T T	21. Signature of Funerel Service Licensee		ddress of Fecility		No jour y							
SE S	Smith Funeral Home											
	22a Port 1 Fater the disease or expedient into that accord		Main Street	Keyser,								
-	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line.  Approximate Interval Between Onset end Deeth											
ysician												
Medical caminer	Immediate Cause (Final disease or condition	About Six										
9,816	Immediate Cause (Final disease or condition resulting in death)  e. CONGESTIVE HEART FAILURE  Due to (or es e consequence of):											
	CORO	WHEY ARTERY	DISEASE		Abow-Six							
ding physician end se es the bunal-trenait	Sequentially list conditions,  Due to (or es e consequence of):											
EX EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or Injury											
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use e	d											
ched ched	Part II. Other significant conditions contributing to death bu	t not resulting in the underlying ceus	e given in Pert I.		use contribute to the cause of death							
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sete has been signed by the ette pege 2 should be detached for Completed by Physicia	RIGHT HEMICOLECTON	4 POR BLEES	Inc	24e. Wes en eutoperformed?	psy 24b. Were autopsy findings eveilable prior to completion of cause							
hes b					of death?							
pege Com	CERERROUMSCULAR ACC	MAJOA MAJOA	L DEARESSIAN	1 ☐ Yes 2	OSONO 1 ☐ Yes 2 ☐ No							
rector, peg	25. Wes cese referred to medical		26. Place of Deeth (C	theck only one)								
	examiner?  1 Yes 2 No Hospital: 1 Anpatier	nt 2 ER/Outpetient 3 DOA	Other:		6 □Other (Specify)							
2 2 -	27. Menner of Deeth 28e. Dete of Injun			. Describe how injur								
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is after deam.  a) Diractor: After to led in by the funera  Certification:	4 Homicide determined 286. Plece of Injurial building, etc.	ry - At home, ferm, street, factory, of (Specify)	201.	City or Town, Stete	)							
5 E E												
n 24 hou he Fune pletely fil edical	29a. Certifier  (Check only  2 Medical Examiner: On the basis of	examinetion and/or investigation, in	ne time, date end plece, end my opinion, deeth occurred o	due to the cause(s et the time, date end	) end manner es steted. d place, end due to the ceuse(s)							
the I	one) and menner stell			1 -0.1 -0								
within 24 hours after de To the Funeral Directo Completely filled in by the Medical Certific	29b. Signeture and title of certifier		cense number	29d. Da	ite signed (Month, Day, Year)							
8	H. Sedhin		26907	ADI	RIL 24, 2000							
	30. Neme end eddress of person who completed ceuse of de			ACI	2000							
245	Harlit Sidhil ODE Rie		and Cumb	perlana	1, MD 21502							
	31. Dete filed (Month, Day, Year) 32. Registre	r's Signature,	rad Cami	Jet I WITE	1100 01000							
State	APR 2 7 2000 See	& South										
Registrar	APR G I LUUU KATA	N. WIVELL										

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14731

			HE W	Certifica	te of l	Death		Reg. No.	00	14701			
	1. Decedent's Neme (First, Middla,	Last)					2. Data of		Yaar	3. Tima of Death			
Physician /Medical	J.	AMES D		GOLDS	VORTH	Y		il 20,	2000	1:28 am			
Examiner	4a Facility Nema (# not institution, Memorial Hospi		)		4	b. City, To	wn, or Location of I		County of Death				
uneral irector	5. Social Security Number 216 - 66 - 0283	Sax 7. A	ga (fn yrs. last birth	rs. If Und	ar 1 Yaar Days	If Undar Hours		of Birth	9. Birth	nplace (State or Foraign			
	Usual Rasidence of Decedent		Lane Chu Tour	and anotion						1011-11-05-11-5			
ehow dat	10a. Stata 10b. County 10c. City, Town or Location									10d. Inside City Limits  1X☐ Yas 2☐ No			
or 28a-fe be notified Director	ALLE	gany						40a Ciri	an of What Co.	**			
iner must	11. Marital Status	12. Was Decedant Armed Forces 1  Yes 2	t Evar in U,S.	13. Was Dec	edant of H	ispanic Ori n, Maxicar	gin? (Specify Yes on, Puarto Rican, ato	or No- 1	4. Raca - Amar Black, Whita				
Executor Fu	3 Widowed 4 Divorced	1 ☐ Yes 2☐ If Yas, Giva Yaar or Datas:	,	1 🗆 Yas		Specify:			Specify:whi				
dical	15. Decedant's (Specify only highast	Education grade completed)	16a. I	Decedent's Us	ual Occup	ation during mos	t of working	16b. Kin	nd of Business/I	ndustry			
Completed	1Elementary/Secondary (0-12)	Collega (1-4or		Decedent's Usual Occupation Giva kind of work done during most of work iffa. DO NOT usa retired)  NET Employee				Head S		tart			
To Be C	17. Fether's Name (First, Middle, Last) Paul R. Goldsworthy  18. Mothar's Nama (First, Middle, Maiden Surmama) Carol E (Moon)												
	19a. Informant's Name/Relationship (Type, Print) Carol E. Goldsworthy 412 Fayette Street; Cumberland MD 21502												
eny injury or other once.	mother 20a Mathod of Disposition		20b. Place of camatan	Disposition (Na	ama of othar place	ea)	Data	20c. Loc	cation - City or T	Town, Stata			
	Burial 2 Cremetion 3		St. Mai	y's C	emet	ery	4/22/	Cum	berlan	d, MD			
once	21. Signature of Funeral Service Licensee Searche Mrs. oFaireral Home P.A. Cumberland, MD 21502												
	23a. Part1. Entar the disease, or e	omplications that cause	d the death. Do no	ot antar tha mo	oda of dyin	g, such as	cardiac or raspiral	ory errast,	1	Approximete Intarval Batween			
ian	shock, or haart failure. List d	ny die cause on each	iii ie.						1	Onsat and Daath			
cal ner	Immediate Cause (Final disaasa or condition	Massiv	e myocar	dial i	nfarc	tion			:	< 1 hour			
	Dua to (or as a consequence of):												
nlne													
/Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or Injury	Due to (or as a consequence of):  c. Diabetes mellitus, insulin dependent								38 years			
/Medical Examir	that initiated evants rasulting in death) Last  Due to (or as a consequanca of):  Hypertension									> 5 years			
lan		d							1	, - , - , - , - , - , - , - , - , - , -			
Physician	Part II. Other eignificant condition	contributing to death	contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death?			
d be deteched for u									1 Yes 2 No 3 Probably 4 10				
Completed b			•		Ť,	14	24a.	Was an autop performed?		Vara autopsy findings vailabla prior to complation of causa			
9								1  Yes 2 d		t déath? □ Yas 2□ No			
Be Corr	25. Was casa rafarred to medical					26. Place	a of Daath (Chack	only ona)					
\$ C	axaminar? 1 Yas 2 No	Hospital: 1 ☐ Inpat	iant 200 ER/Out	patient 3 C	Oth Oth	ar: 4□ N	ursing Homa 5 🗆	Residence 6	Other (Spec	eify)			
-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigs	28a. Data of Inj (Month, D	ay Year) 28b. Ti	ma of jury M	28c. Injur Wor	yat k? Yas 2□		28d. Dascribe how injury occurred					
led in by the tuneral Certification:	3 Suicida 6 Could no determin	De Blace of Injury. At home form street factors office. 281 Location (Street and Number								ral Route Number,			
completely filled in by the funer		Physicien: To the best aminer: On the basis of and manner's	ot axamination and										
completely filled in by the fu	29b. Signature end title of certifier	- 1		2	9c. Licans	e number		29d. Dat	a signad (Monti	n, Day, Yaar)			
5	1. anne	tustan	unfel	E, MD	DOO	50037		Apr	il 24	2000			
	30. Nama and addrass of person w	no complated causa of	daath (hóm 23a) (1	Type, Print)	200.	20001		TIPL	01				
mis	Dr. Annette War				Wes	terno	ort, MD	21562					
State	31. Data filed (Month Day, Year) 7		lrar's Signatura	4	lan	100							
Registrar	111111111111111111111111111111111111111	-444		~	MOU	as I							

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year EMILY GRIFFIN 4b. City, Town, or Location of Deeth 2000 16 4a Fecility Neme (If not institution, give street end number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY 5. Social Security Number 215-14-3184 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 M 2 XF Days Hours Usual Residence of Decedent 10e State 10c. City. Town or Location 10d. Inside City Limits WICOMITO m SALISBURY 1KYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21804 30617 SATTERFIELD COURT USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) US POSTAL SERVICE Elementery/Secondary (0-12) College (1-4or 5+) POSTMASTER 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) GUY WESLEY CONNETON YIDA M. THULOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 38405 STATELINE TO CREEN BACKVITTE, YA 213356 APAIL DOLYNY DAUGHTEK 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 ☐ Cremation 3 ☐ Removat from State YPODO WHITEHINEN, MD WHITE HAVEN CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Coltant took 1 Coltant took 1 22. Name and Address of Facility MESSICK FUNERAL HOME TO GOX 61 Sivery MD 21814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21. Signeture of Funeral Service Licensee Cytum Rescie Approximete tntervat Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Due to (or es e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last to (or es e consequence of) Confustion Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician/Medical Š Completed Be To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or items 23s

permit. Pages 1 and 2 should be filed within 72 hours aftar d Department of Heelth and Mental hygiena. Important: If item 27 is marked other than "natural", or frem eny injury or other traumatic event, the Medical Examinations.

Physician /Medical

Examiner

Saltimore, Maryland 21215-0020

death

Director

Funeral

Completed

Be

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

Certification: 1 Natural 2 Accident 3 Suicide 4 Homicide 24 hours 29a. Certifier (Check only one) To the To To the I

Registrar

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signeture end title of certifier

29d. Date signed (Month, Dey, Year)

JALIS BUKY

EASTERN J HORE

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

BADROS Spistrac's Signature

**6** 2000

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# **Funeral** Director Show

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PHYSICIAN: GEORGE, VERNON

2

JAME KNOWN

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 2:45 AM April 16, 2000 VERNON QUINCY **GEORGE** /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner VA Maryland Health Care System Cecil Perry Point If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) August 22, 1927 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys 1 M 2 □ F 452-30-8775 72 Texas Usual Residence of Decedent filed withIn 72 hours aftar death with tha Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits important; if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified as 1 ☐ Yes 2 ☑ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Loch Raven Rd. 21804 USA Funeral 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ⊠ Yes 2 No Navy If Yes, Give Yeer or Detes: WW TT 1 Never Merried 2 XMarried 1 Yes 2 No Specify: White þ Specify 3 ☐ Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'e Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiena. Welder Welding Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Riley B George Clara C Shipman 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 912 Loch Raven Rd., Salisbury, MD 21804 Mary Anne George/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Maryland Veterans Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 4/19/00 Hurlock, MD 22. Name end Address of Fecility Holloway Funeral Home Professional Association 21. Signeture of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 iarro 4. DOMPOR MOJOSI Approximete Intervel Between Onset end Deeth 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) unknown Pneumonia Examiner Due to (or es e consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) P.O. Box 68760, Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 88 signed by the aid Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Parkinsonism, Dementia Division of Vital Records, Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? paga 2 should 24a. Wes en eutopsy performed? cartificata 1 Tyes 2X No 1 ☐ Yes 2 ☐ No funaral director, 8 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Aftar 1 Neturel 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 24 hours after death.

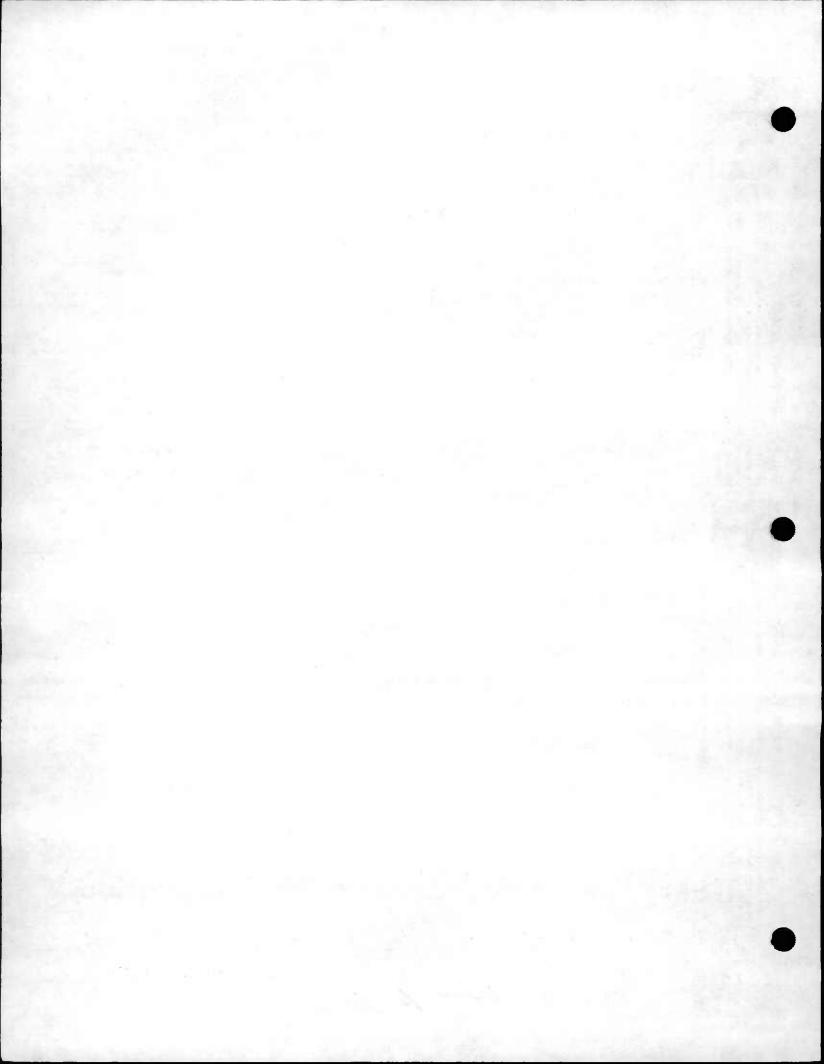
Funeral Director: A 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier within 24 ho To the Fune complataly f (Check only one) ŝ 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2 Samur Khelri D0052064 April 16, 2000 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Samir Kheiri, M.D. VA Maryland Health Care System, Perry Point, MD 21902 31. Dete filed (Mooth, Day, Year) 2000 32. Registrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4733.

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death IANGARE. **Physician** GRUIF /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) Examiner 4c. County of Death Potomac Valley Nursing Home Montgomery 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

79 Yrs. Months Days Hours Min. (Month, Day, Year)

April 19 1920 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 579-12-3239 1 ☐ M 2 💢 F Director Va. Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mentel Hygiene. Importunt: If Item 27 is marked of user than "natural", or Items 28 or 288-f show any Injury or other traumatic event, the Medical Examinary. 10a. State 10b. County 10c. Cify, Town or Locetion al', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Washington Funeral Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5425 Connecticut Ave. #509 20015 USA 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedanf Ever in U,S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nurse health care 12 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informanf's Name/Relationship (Type, Print) 5425 Connecticut Ave. #509, Washington DC 20015 Samuel C. Gruiff (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 4-19-2000 Sykesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensea P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a. CHRONIC OBSTRUCTIVE PULMONARY

Due to (or as a consequence of):

DISERSE /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The lew requires that the death certificate be executed bunal-trensit Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or as a consequence of): ing physician e Box 68760. Physician/Medical Due to (or as a consequence of): P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 ☐ No of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpafienf 3 ☐ DOA Nursing Home 5 Rasidance 6 Other (Specify) nours efter deeth.

neral Director: Afte, this
filled in by the funeral di this 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours effer d
To the Funeral Direct completely filled in by 4 Homicide

State Registrar

Medicai

29a. Certifiar

29b. Signature and \$

31. Date filed (Month, Day, Year)

WACTER E. GOOTH MY

32. Registrar's Signature

APR 20

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

1299 LAMBERTON OR WHEATON, MD 20902

Certifying Physician: To fhe best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

2 Medicel Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner-stated.

29c. License number

D01120

29d. Date signed (Month, Day, Year)

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### Please Type or Print in Black Indelible ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	1. Decedent's Name (First, Middle, Las	st)					2. Dete of I	Death Dey	Yeer	3. Time of Death
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Examiner	4e Fecility Neme (If not institution, give	e street end number)	4.1			4b. City, Town,	or Location of Dec			<u> </u>
	Memorial Hospita	1				Cumber	land	Alleg	anv	
uneral	5. Social Security Number 6. S	ex 7. Age (	n yrs. last birth	dey) If Und Month	er 1 Year Deys	If Under 24		irth	9. Birthple	ce (Stete or Forei
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POST IN	Usual Residence of Decedent									
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or 28a-fa be notified Director	10e. Street and Number			10f. 2	ip Code			10g. Citizen of V	Vhet Country	1?
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or Branch	1 Never Merried 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give			21 No			Specify		
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Ne ver	17. Fether's Neme (First, Middle, Last)					18. Mother's	Name (First, Midd	le, Maiden Sumem	(0)	
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Tie marked other than "natural", or flams 23s or 28s-f show traumstic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	19e. Informant's Neme/Reletionship (	***			- 1			ber, City or Town,		ode)
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Y == 0	1 ☑ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific					APRIL 30	2000	CUMBERL	AND MA	ARYLAND
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niner	Immediate Ceuse (Final disease or condition resulting in deeth)	a CORONA	RY A	RTER	Y	DISEA	SE		; 5	5 YRS
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Sin by ertif	4 Homicide	building, etc. (	Specify)				City or 1	own, State)		
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pletaly fil edical		niner: On the basis of ex	aminetion end/							
To the Funeral Director: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com	29b. Signeture and title of certifier	J. J. Monator states		. 2	9c. Licen	se number		29d. Date signe	d (Month. De	ey, Year)
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/	Dr. Robustiano	J. Barrera	500 Me	morial	Ave	nue, Su	ite 201	Cumberla	ind, M	D 2150
State	31. Dete filed (Month, Day, Year)	32. Registrer's	Signeture	,	,					
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DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician Year ROBERT DALE HURST April 15, 2000 1:30 PM /Medical 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1121 Resden Run Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□ F 226-58-1126 Yrs. Director 54 February 6,1946 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "natural", or itema 23a or 28a-f ahor the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 Yes 20 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1121 Resden Run 21804 Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglane. Important: If Item 27 is marked other than "naturel", or iten eny injury or other treumatic event, the Medical Francing 1 文Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Navy 1 Yes 2 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vice President/Estimator Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilmoth J.C. Hurst Ruby Shrewsbury 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 Resden Run, Salisbury, MD 21804 Joanne R. Hurst/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4/18/00 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service License 22, Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 234 Pag. Enter the disease, or complications and saused the back, or heart failure. List only one cause on each fine Approximate Interval Between Onset and Death with. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) MALIBNANT MELANOMA ZYRS Due to (or es a consequence of): Examiner physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 8

Physician /Medical Examiner

Saitimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vitai or Attending Physicien:

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Physician/Medical à Completed

been signed by ti should be detech s certificate hes b director, page 2 s director, Be Certification: To After thi funeral To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fundaments.

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be

completion of cause of death? 1 ☐ Yes 28 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 ☐ Yes ANO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide All contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

D36576

29d. Date signed (Month, Day, Year) 00

24b. Were autopsy findings aveilable prior to

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

RONALD RAVITE MD

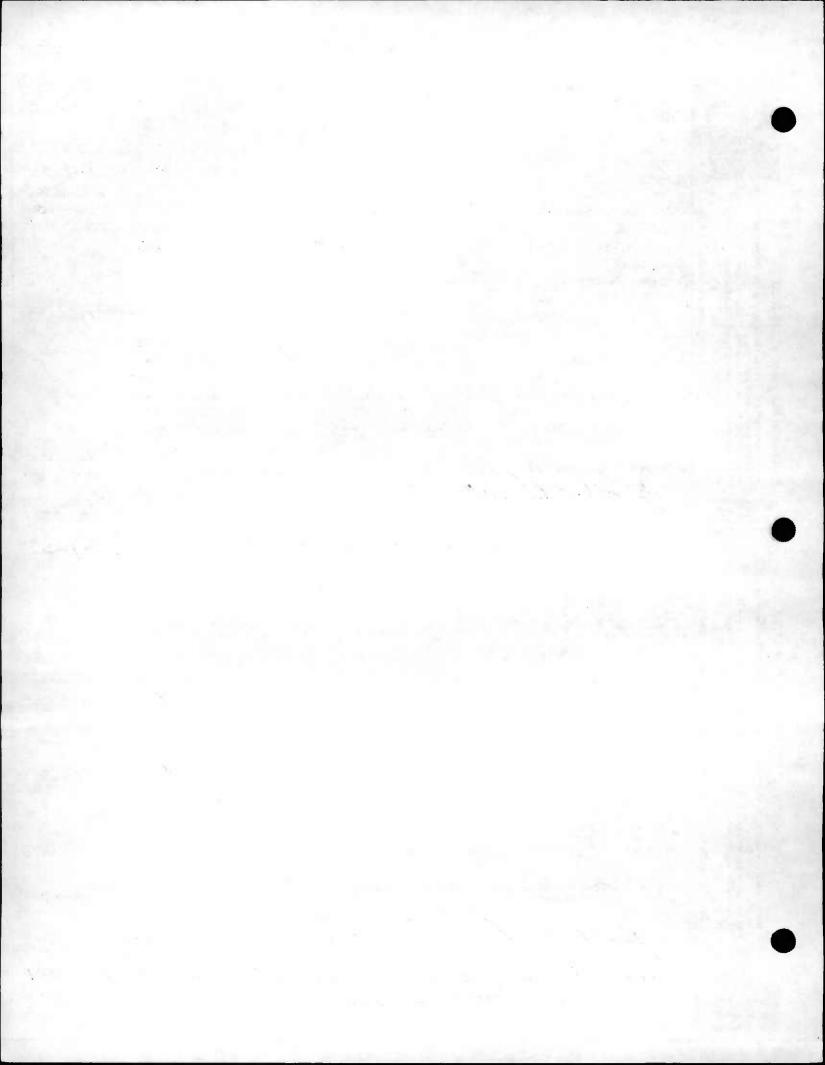
32 Registrar's Signature

560 RIVERSIDE DR SALISBURY MD 21801

State Registrar

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Amended #26, NLS, 4/24/00, Allegany Co.

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14737

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Examiner	4a Facility Nama (# Sacred H			um <i>ber)</i>				Cumbe	erlar		Alle	nty of Death egany	
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permit. Pag Department Important: I any Injury o	21. Signeture of Fun	aral Sarvice Lice	nsee		22					Home,	P.A.	2150	12
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To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Diractor: After this certificate he completaly filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one)	Certifying Pr	miner: On tha										
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Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14738 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Winifred Hemsley 26 2000 April 2030 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Kent & Queen Anne's Hospital Chestertown Kent Hours Min. April 20, 1922 Baltimore, MD If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 X F 78 Yrs 216-24-1887 Usuel Residence of Decedent 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits tX Yes 2 No Maryland Kent Chestertown 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 7890 Whitworth Court USA 21620 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Dr. Charles Reid Edwards Ruth Conner 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2826 Rosemary Lane, Falls Church, VA 22042-1812 Vickie L. Conant 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 \( \mathbb{T}\) Burial 2 \( \subseteq \text{Cremetion} \) 3 \( \subseteq \text{Removel from State} \) 4 \( \subseteq \text{Donetion} \) 5 \( \subseteq \text{Other} \( (Specify) \) Paul's Cemetery 5/1/2000 Chestertown, Mayrland 21. Signature of Funeral Service License Fellows, Helfenbein & Newnam Funeral Home, P.A. Kick 130 Speer Road, Chestertown, Maryland 21620 23a. Part . Enter the disease, or complications that caused the death. Do not as shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) CONGESTIVE HEART FAILURE CARDIOMYUPATHY DILATED Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑ Unknown GASTROINTESTINAL BLEEDING 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy parformed? 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nothed at

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medicai

attending physician and for use as the burial-transit \$ certificate Certification: To

Completed Be

edical

1□ Yes 3☑ No

5 Pending investigation

6 Could not be determined

27. Menner of Deeth

Naturel 2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

The law requires that the death certificate be assecuted To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

> State Registrar

A When ms

D0041587

1 Tyes 2 No

29d. Date signed (Month, Day, Year) 00

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Neme and address of parson who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620

28h Time of

28e. Plece of Injury - At home, farm, streef, fectory, office building, etc. (Specify)

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

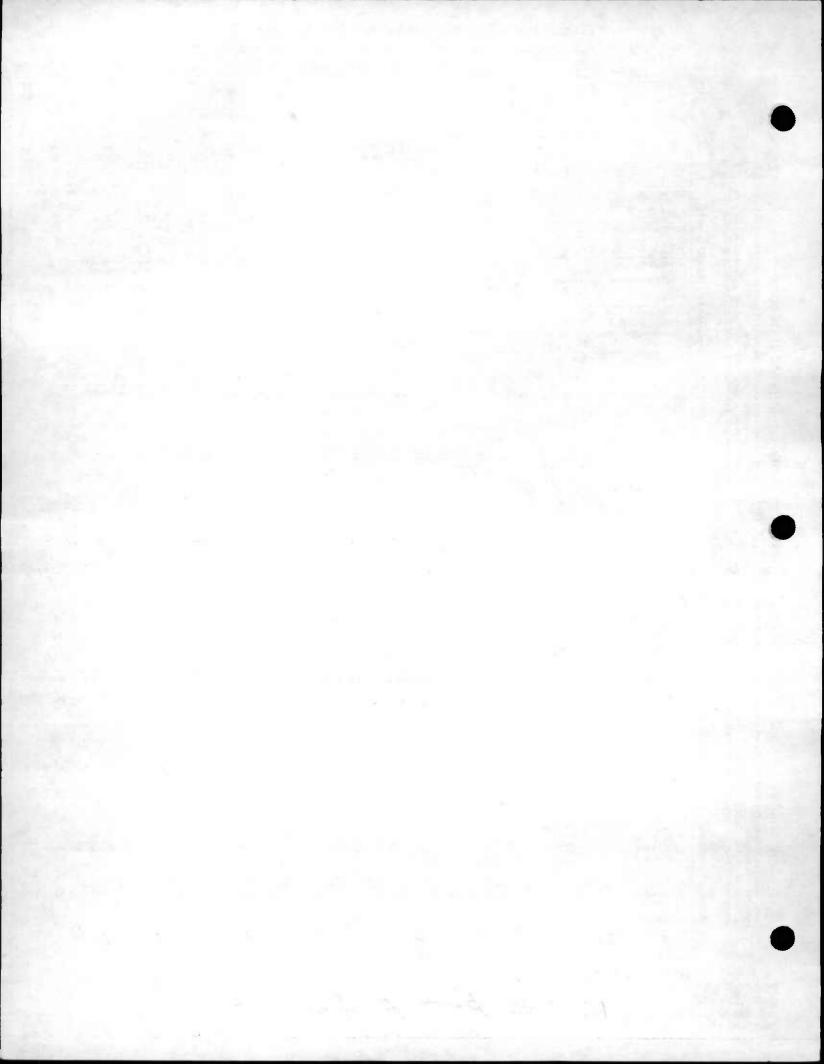
APR 2 8 2000 >

28e. Dete of Injury (Month, Dey Year)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

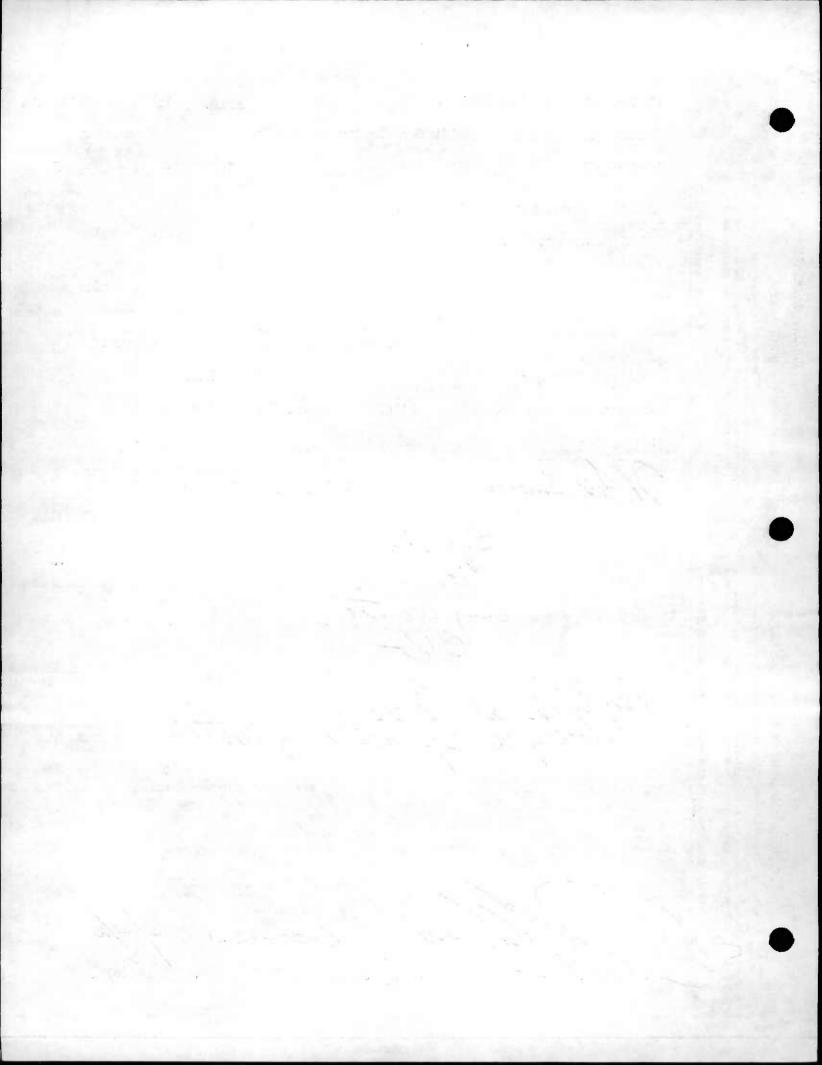
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.



# HUDSON, CATHERINE land 21215-0020

ian ical _		ne (First, Middle, La			Certificate of	Health and M f Death	2. Dete of De Month	Reg. No.	3. Time of Death
			ARIE HUE			sh City Town as I	APRIL		000 9:35 P.M
ner			re street end number, a and Reh		on Center	4b. City, Town, or Lo	ocation or Deeti		cester
5	5. Social Security N	Number 6. S	Sex 7. A	ge (In yrs. last bi		ar If Under 24 Hrs.	8. Date of Bir (Month, De		Birthplece (State or Forei Country)
	222-14- Usuel Residence of	-2061	1□M 2 <b>X</b> F	85	Yrs. Months Deys	s Hours Min.	11/7/	1914	MD
-	10a. Stete	10b. County		10c. City, Tow	n or Location				10d. Inside City Limi
	MD	Worce	ster	Be	erlin				1 <b>□X</b> Yes 2 □ N
1	10e. Street end Nu 9715	mber Healthwa	y Dr.		10f. Zip Code	21811		10g. Citizen of Who	et Country?
1	1. Maritel Sletus 1 Never Marr 3X Widowed	ried 2 Married	12. Wes Decedent Armed Forces' 1  Yes 2  If Yes, Give Year or Dates:	? [No	13. Was Decedent of If Yes, specify Cu	f Hispenic Origin? (Spuben, Mexicen, Puerto o Specify:	ecify Yes or No Rican, etc.)	14. Race - Black, Specify:	Americen Indian, White, etc. white
_	(Spec	15. Decedent's Ed		16a	Decedent's Usuel Occi (Give kind of work don	upation e dunna most of work	ina	16b. Kind of Busin	ness/Industry
	Elementery/Seco		College (1-4or	5+)	(Give kind of work don life. DO NOT use retir Waitress	red)		Posts	want
1		(First, Middle, Last)	)		waitress	18. Mother's Neme	e (First, Middle.	Restau Maiden Sumeme)	irant
		rge Crop				The state of the s	Willian		
1		eme/Reletionship (			D. Mailing Address (Street 10105 Bonit				ete, Zip Code) 1842
2			Removel from Stete	cemete	of Disposition (Neme of try, crematory or other pi et Memorial		Date 4 / 24 / 00	20c. Location - Ci	
2	21. Signature of F	gerel Service Licen	mbale		22. Name and Add	iam St. Be	_	Funeral ID 21811	Home
1	shock, or hee Immediate Cause diseese or condition resulting in deeth)	(Final	e.	eps	not enter the mode of dy				Approximete Interval Between Onset end Death
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1	that initiated events resulting in death)	Lest	d	00	N				
t	that initiated events resulting in death)	L	d.	out not resulting	with underlying cause of	given in Pert I.			ibute to the cause of deat
by Physician/Medic	that initiated events resulting in death)	L	d.	out not resulting.	righte underlying cause of	given in Pert I.	10	Yes 2□No 3	
P	that initiated events resulting in death)	The till	d.	cut not resulting	withe underlying ceuse of	Aspe	10	Yes 2□No 3	Probably 4 Unkno
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	that initiated event: resulting in death)  and II. Other aignification.  25. Wes case refer examiner? 1  Yes  2	red to medical	Hospitel: 1 Impati 28e. Dete of Inju (Month, De	ent 2 ER/Oury ay Year) 28b.	utpelient 3 DOA Time of Injury W	26. Plece of Deets  26. Plece of Deets  Other:  TNursing Ho  iury et ork?  Yes 2 \( \) No	1   1   1   1   1   1   1   1   1   1	Yes 2 No 3  Yes 2 No  Yes 2 No  One)  dence 6 Other now injury occurred	□ Probably 4 □ Unknote  24b. Were eutopsy findings eveileble prior to completion of cause of deeth?  1 □ Yes 2 ▼ No  (Specify)
2 2	25. Wes case referexaminer?  1 Yes 20.  7. Menner of Deat 1 Neturel 2 Accident 3 Suicide	rred to medical No th 5   Pending investigation 6   Could not be determined	Hospitel: 1 Inpati  28e. Dete of Inju (Month, Detention of the building, electron)  28e. Plece of Input (Month, Detention of the building, electron)	dent 2 ER/Oury 28b. jury - At home, fetc. (Specify)	utpelient 3 DOA Carrier of Injury M 16	26. Plece of Deet  Other:  Thursing Ho  iury et  ork?  Yes 2 No  e	1   1   1   1   1   1   1   1   1   1	Yes 2 No 3  Yes 2 No  Yes 2 No  One)  dence 6 □ Other now injury occurred  Street end Number vn, Stete)	□ Probably 4 □ Unkno  24b. Were eutopsy findings eveileble prior to completion of cause of deeth?  1 □ Yes 2 ▼ No  (Specify)  or Rurel Route Number,
edical certification: To be completed by Physician Medic	25. Wes case referexaminer? 1 Yes XX 27. Menner of Deat 1 Neturel 2 Accident 3 Suicide 4 Homicide	rred to medical No  th 5   Pending investigation 6   Could not be determined	Hospitel: 1 Inpati  28e. Dete of Inju (Month, Detention of the building, electron)  28e. Plece of Input (Month, Detention of the building, electron)	dent 2 ER/Oury 28b. jury - At home, fetc. (Specify)	utpelient 3 DOA Time of Injury M 1[ arm, street, factory, office a, death occurred at the addor investigation, in my 29c. Licer	26. Plece of Deet  Other:  Thursing Ho  iury et  ork?  Yes 2 No  e	1   1   1   1   1   1   1   1   1   1	Yes 2 No 3  Yes 2 No  Yes 2 No  One)  dence 6 □ Other now injury occurred  Street end Number vn, Stete)	□ Probably 4 □ Unkno  24b. Were eutopsy findings eveileble prior to completion of cause of deeth?  1 □ Yes 2 ▼ No  (Specify)  or Rurel Route Number, er as stated. d due to the cause(s)

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ammeded # 2, 4/12/2000, DLB, St. Mary's Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2000 er Day AMONTH 3:56 PM Mary Havill 08-00 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) Months Days 1 M 2 SF Yrs. 579-12-7609 October 30, 1920 Georgia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Numbe 40825 Spring House Lane 20650 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12th Grade Sales Clerk Retail Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold John Brigham Laura Daniel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Harry D. Havill, Jr. (Spouse) 40825 Spring House La., Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State West 4/14/2000 Clintonville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) End of the Trail Cemetery 22. Name and Address of Facility. Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licens rdiner P.O. Box 270, Leonardtown, Maryland 20650 23a. Part I Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carlinoma 949m 4845 (611 Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Lest Due to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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Physician/Medicai

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Completed

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Certification:

cai

29a. Certifier

(Check only one)

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dapartmant of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or frems 23e or 28a-1 show enty injury or other traumatic event, the Medical Examena must be notified at the page.

Baltimore, Maryland 21215-0020

physician and is the bunal-transit use as the attending p signed by the a peen s certificate has t Aftar this funeral di To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afta completely filled in by the fun.

The law requiras that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records.

Attending Physician:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chromic obstactive  $\subset$ 25. Was cese refer

24e. Wes an autopsy

ongest	ve he	int.	failure	24	te. Wes an a performe
Porey	noon 4				1 ☐ Yes
red to medical				26. Place of Death (Che	ck only one)
	Hospital:		Ott	ner .	

24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No

examiner?	lo
27. Manner of Death	
1 Natural	5 Pending
2 Accident	investiga
2 Cuicido	6 ☐ Could no

1 Annatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Injury

1 ☐ Yes 2 ☐ No ation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b.	Signature	and title	of certifier	
	•	BA	other	-

29c. License number D28035

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

MO 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 04-08-00

KOLIA M.D. BASIRMOHMAD F.

2000

9135 Piscataway Rd. #210 Clinton MD 20735

State Registrar

32. Registrar's Signature oaks

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ALTERNATION OF STREET

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4761 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Daath **Physician** Month Dey Jacob Johnson April 12 2000 4:20 p.m. /Medical 4a. Facility Name (If not institution, giva street and number) Magnolia Hall 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Nursing and Convalescent Home Chestertown If Undar 1 Yaar Months Days If Under 24 Hrs. 5. Social Security Number 212-12-1240 Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Hours Yrs Director 93 Md. 4-20-1906 Usual Residance of Decedant the Marylend permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mantel Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any hydry or other traumatic event, the Medical Examinet must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Kent Director Rock Hall 1 ☐ Yes 2 🙀 No 10e. Street end Number 10f. Zip Code 10g, Citizan of What Country? 5451 Crosby Road 21661 U.S.A. Funeral 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 No Specify: þ Black Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Laborer Construction 8th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Daniel K. Johnson, Sr. 2 Mary Louise Bentley 19a. Intormant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Bessie Beck - Daughter 144 Winder Rd., New Castle, Dela. 19720 20b. Place of Disposition (Nama of camatary, cramatory or other plece) 20e. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 Cremetion 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify) 4/17-00 Rock Hall, MD Aaron Chapel Cemetery 21. Signature of Funeral Service Licenses 22. Name end Addrass of Facility James A. Perkins Funeral Service, P.O.Box 143, 21106 Rock Hall Ave., Rock Hall MD 21661

23a. Partf. Enter tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Presensice 3004 Examiner Dua to (or as a consaquence of): ician/Medicai Examiner Corp The lew requires that the death certificate be axecuted attending physician end for use es the burial-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury Dua to (or as a consequance of): that initiated evants rasulting in daath) Lest Dua to (or as a consequance of): After this cartificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy tindings evelleble prior to complation of cause of death? Completed 24a. Was an eutopsy 1 🗆 Yas 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after deeth.
Funeral Director: After this cartifica staly filled in by the funeral director. Be 25. Was casa retarred to medical 26. Place of Death (Check only ona) axaminar? 1 Yes 2 No Other: 2 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicide 6 Could not be datamined 28f. Location (Straet end Number or Rural Routa Number, City or Town, State) Placa of Injury - At home, ferm, streat, tactory, offica building, atc. (Spacify) 4 ☐ Homicide • Funeral edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted. within 24 hou To the Fune completely fil 29a. Certifiar (Check only one) Ę 29b. Signature, and titla ot certifiar 29c. License number 29d. Data signed (Month, Dey, Year) 0 D-42137-24

Road Suite 5 Chestertown, MD 21620

State Registrar 30, Name end, adrass of person who con(peted cause of deeth (Item 23a) (Type, Print)

122 Speer

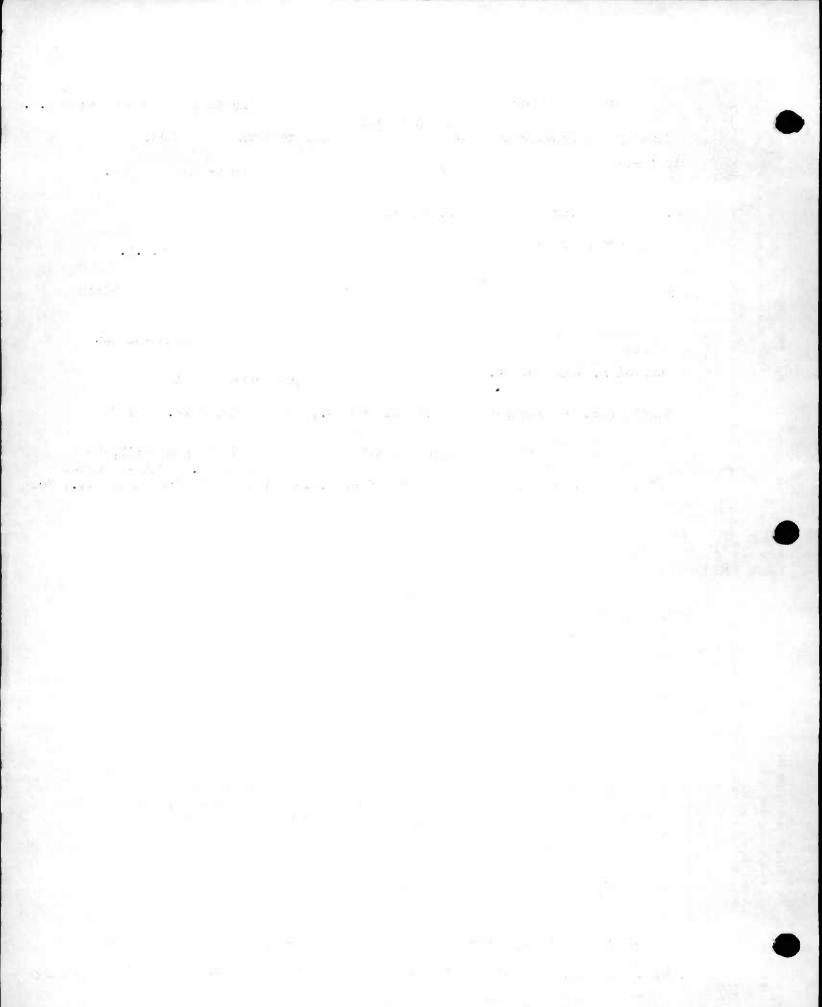
32. Ragistrar's Signeture

C. Seymour, M.D.

31. Data filed (Month, Day, Year) APR 1 4 2000

Baitimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State

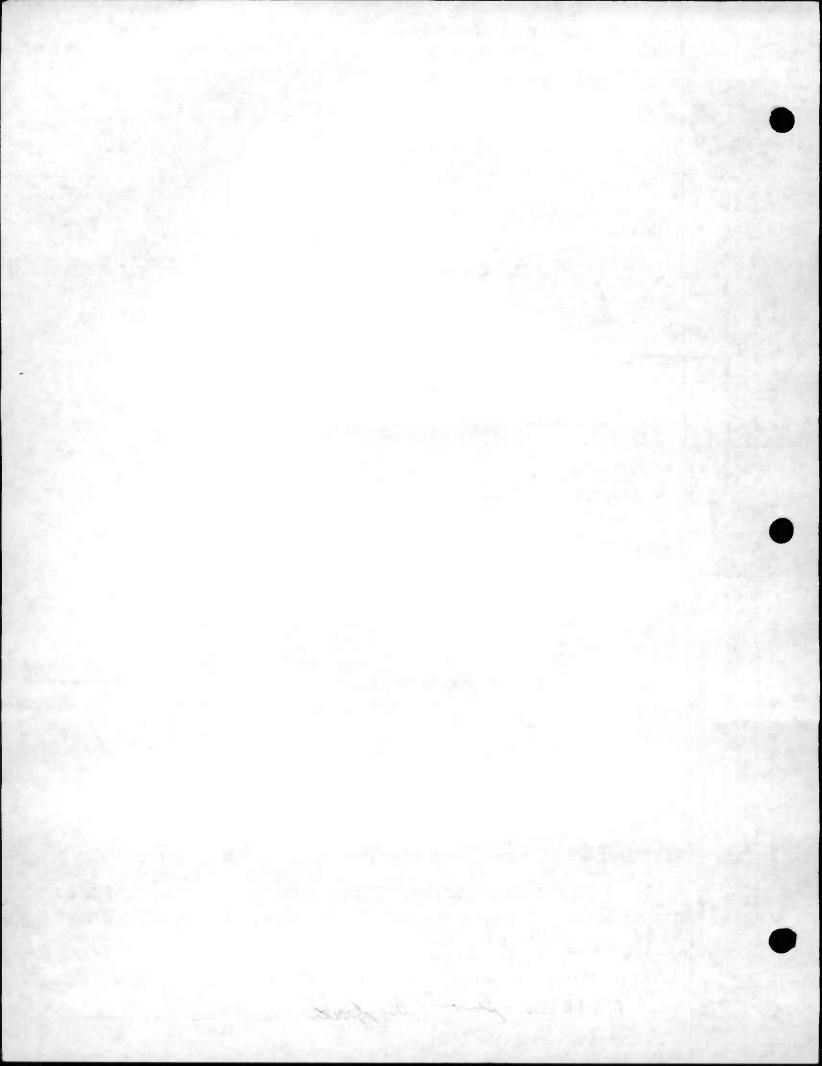
Registrar

31. Data filed (Month, Day, Year)

APR 18

2000

32. Registrar's Signatura



00-2285-033 Chritopher A. Kline Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14743

/W				Ce	rtificate of i	Death	F	leg. No.	
1	Physician /Medical	Decedent's Name (First, Middle, I     ALLAN		STOPHER	KLINE		2. Date of Dea		Year 3. Time of Death 7:49 P.M.
	Examiner	4a Facility Name (If not institution, g Prince George's	rive street and number) Hospital (	Center		4b. City, Town, or L neverly	ocation of Death		of Death e George's
	Funeral Director	169-52-3220	Sex 7. Ag	e (In yrs. last birthday, 28 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day May 27,	7. Year) 1971	9. Birthplace (State or Foreign Country) California
	the Maryland 28e-f show notified at	Usual Residence of Decedent  10a. State 10b. County  Maryland Char	les	10c. City, Town or L Waldor					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the Ma 23a or 28a-fa uni be notified al Director	10e. Street and Number 2879 Starling	, Drive		10f. Zip Code 206	01		10g. Citizen of V	
020	urs efter dea lut, or items taminer ma by Funes	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes, 2  Hryes, Give Year or Dates:	Ever in U,S. 13.	Was Decedent of H If Yes, specify Cubs 1 X Yes 2 ☐ No			14. Rad Blad Specify	e - American Indian, ck, White, etc. White
Maryland 21215-0020	y within jiene.	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 9	3+1	dent's Usual Occup e kind of work done DO NOT use retired untant Suj				Derior Court
/land	ges 1 and 2 should be filed for the the hand Mental Hygin if item 27 is marked other or other traumatic event. TO Be CC	17. Father's Name (First, Middle, La James Edward K1				18. Mother's Nam Margarit			"
	1 end 2 sho Heelth end N em 27 le me ther traume	19a. Informant's Name/Reletionship Rebecca Lynn Kli			ing Address <i>(Street</i> Starling				
Baltimore,	0 2 # >	20a. Method of Disposition  1 DaBurial 2 Cremation 3 4 Donetion 5 Other (Special Control of Control			osition (Neme of omatory or other place Memorial		Date 05-01-2		City or Town, State
Balt	pemit. Pe Departmen Important: any Injury phice.	21. Signatura of Furneral Service Co	LEY MC	)1164	The Hunti	t Funeral 156, Wal			20604
68760,	certificate be executed and ding physicien end seas the burial-trensit authority. We dical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a b	Due to (or as a conse	quenca of):	juries			
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		30. Name and address of person who LARON LO	o completed cause of c	leath (Item 23e) (Type		Penn Stre	et, Balt	imore,	Maryland 21201

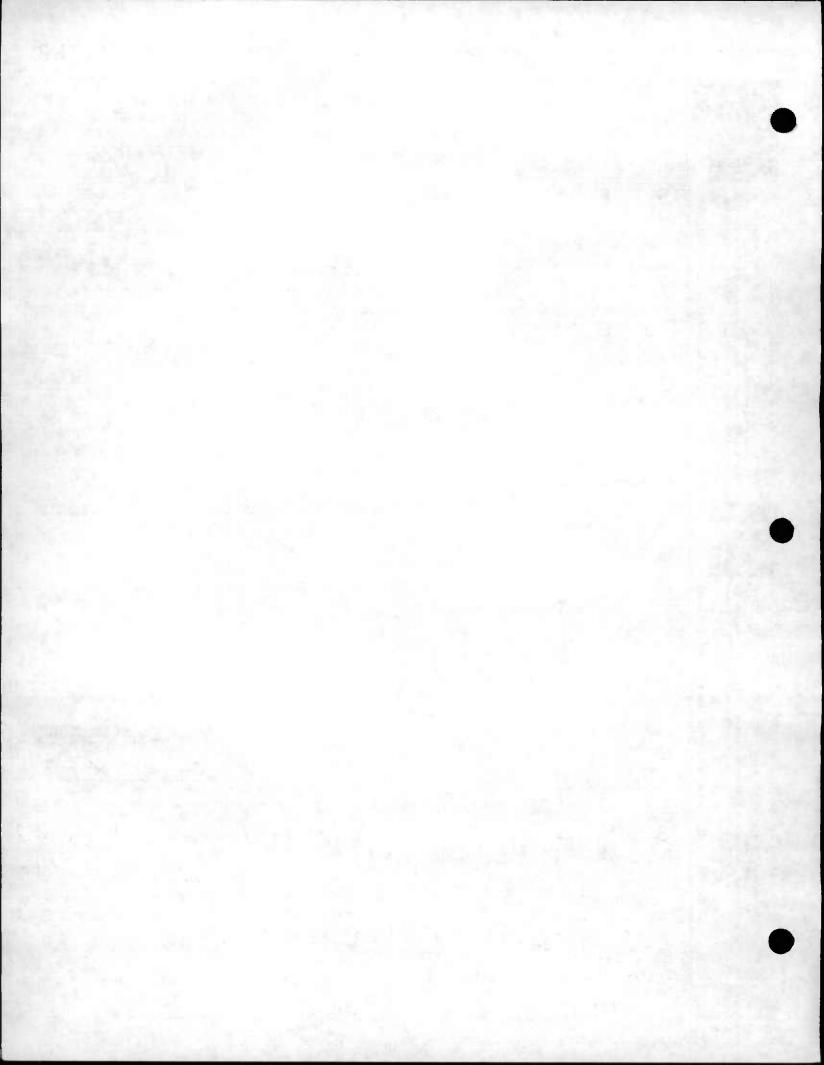
**DHMH 16 Rev 6/95** 

State Registrar

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature



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WILLIAM	KOWALSKI

State of Maryland / Department of Health and Mental Hygiene

	AILEND III		#23 PART 1,			R MEO	G/837	ert	iticat	e of	Death		2. Dete of D	Reg.	No.		2 Tin	ne of Death
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** 2000 April. 15 7:00 p.m. Ginger Ann Longwell /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) March 21,1941 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** Deys 1 M 2 KF Yrs. 59 Director 234-64-3128 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at 1 ☐ Yes 2 No Director MD **Allegany** Barton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? r Reme 23a o 23004 Potomac Hollow Road, S.W. 21521 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 X No 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda complated) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) Collega (1-4or 5+) permit. Pages 1 end 2 should be filed v. Department of Heelth and Mental Hygiel Important: if Nem 27 Is marked other the eny fnjury or other traumatic event, the page. 10 Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 John Yokum Baldwin Ruby Jane Sanders 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Charles Preston/ Friend 23004 Potomac Hollow Road, S.W. Barton, MD 21521 20e. Method of Disposition

1 Burial 2 Cremetion 3 Ramoval from State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State Restlawn Memorial Gardens 2000 4 ☐ Donetion 5 ☐ Othar (Specify) LaVale, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Smith Funeral Home 85 S. Main Street Keyser, 26726 Approximete Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 17 days Septic Shock Examiner Due to (or es e consequence of): Physician/Medical Examiner Ischemic Colitis attending physician end for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760, Mesenteric Artery Thrombosis Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown COPD, Diabetes, Peripheral Artery Insufficiency Records, þ 24b. Were eutopsy findings available prior fo page 2 should Be Completed 24a. Wes an eutopsy peen completion of cause of deeth? hes certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: director, 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funaral 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Division After 5 Pending investigation 1 Naturel To the Hospital or Attending within 24 hours after daath.
To the Funeral Director: Afte completaly filled in by the fun 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

Registrar

30. Nama and address of person who complated causa of death (Ifam 23a) (Type, Prinf) MUS

Medical

29e. Certifier

(Check only one)

APR 2 1 2000

29b. Signeture end fitla of certifier

Martin C. Shargel, M.D. 32. Registrar's Signerare

Holy Cross Hospital

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

29c. License number

D 08944

29d. Date signed (Month, Dey, Year) 4/15/2000

Silver Spring, MD

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State of Maryland / Department of Health and Mental Hygiene 1 4746

			Ce	rtificate of	Death		Reg. No.	
	1. Decedent's Name (First, Middle, La.	st)				2. Dete of De	eath	3. Time of Deeth
Physician	Oliver Raymond L	andis Jr				Month April	21, 2000	1644
/Medical Examiner	4e Fecility Neme (If not institution, giv				4b. City, Town, o	r Location of Deet		
Lammer	Sacred Heart Ho			Halada A Vaa	Cumberla		Allega	
Funeral Director	5. Social Security Number 6. S 579–18–2381	ex 7. Age (In yr	s. last birthday, 7 Yrs.	Months Deys		n. (Month, De	th by, Year) 2, 1922 Ro	Birthplace (State or Foreign Country)  Mney, WV
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vith the Ma t or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Whet	Country?
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her death v r Herrs 23a siner must Funeral	11. Meritel Status  1 □ Never Merried 2 ☑ Married	12. Wes Decedent Ever in Armed Forces?		Wes Decedent of If Yes, specify Cul	Hispanic Origin? ( pan, Mexican, Pue	(Specify Yes or No orto Rican, etc.)	Black, W	merican Indien, /hite, etc.
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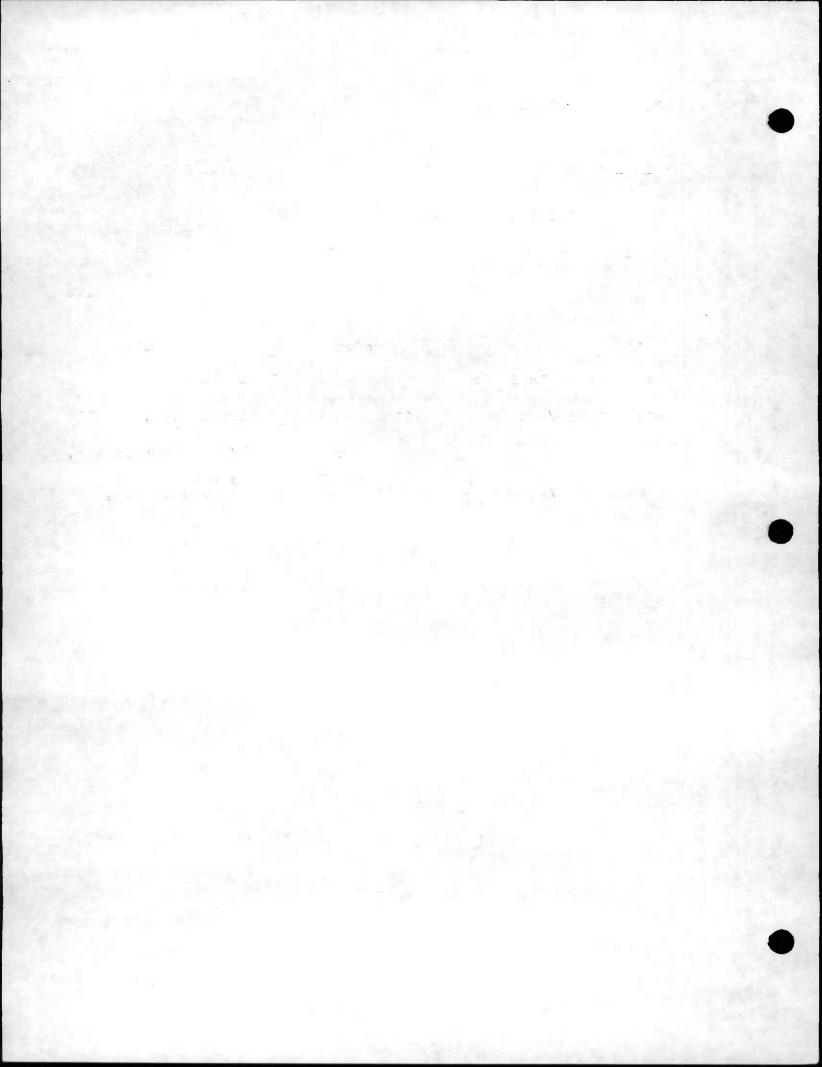
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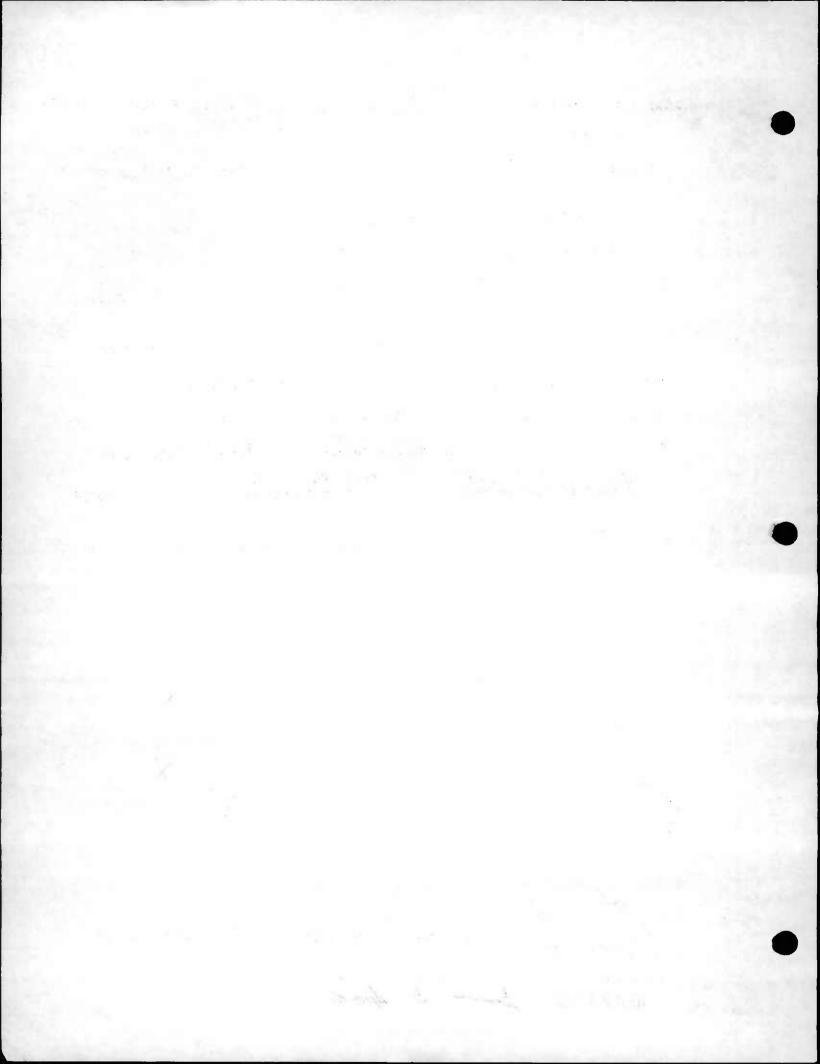
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					Ce	rtificate	of De	ath	R	ag. No.	U	14140					
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0	or Ite		1 X Navar Marriad 2 ☐ Marriad	1 ☐ Yes 2 X No		1 Tas, specily		oecify:	nicen, etc.)		k, White,	etc.					
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Mai	0 0 0		19a. Informant's Name/Relationship (7						rel Route Numbe	r, City or Town,	Stete, Zip	Coda)					
	Health m 27		Yolanda Baker/Si		550 Ob. Place of Dispo	O S. Wa		Street	-	r, WV							
o	Pages 1 er nent of Hea int: if item 3		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐		camatary, crai	matory or otha	r placa)	Α.	Date	20c. Locetion -	City or To	own, State					
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39	permit. Pages Department of Important: if i any injury or once.		21. Signatura of Funeral Sarvice Licen	saa e e e	22	2. Nama and A		Facility eral Ho	277.0								
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Sic	Attanding or death. ector: After by the fune							catl	✓ Accidant investigation 3 Suicida 6 Could not be			М	1 🗌 Yes	2∐No			
Division	or Attan efter deat Director: I in by the						4 Homicida datarminad	28a. Place of Injury - building, atc. (S	At homa, farm, str pacify)	aat, factory, of	fice		28f. Location (Si City or Town		er or Rure	al Route Number,	
	To the Hospital or Attano within 24 hours efter deati To the Funeral Director: completely filled in by the																
	Hospital 24 hours Funeral I	edical	(Check only 2 Medical Exam	sician: To the bast of my inar; on the basis of axa	y knowladga, daath mination and/or in	occurred et the vastigation, in	ha tima, d my opinio	ata and placa, n, daath occur	and dua to tha c red at the time, d	ausa(s) end ma ate and place, a	nner as s and due to	tated. the ceuse(s)					
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						29c. Licansa numbar				29d. Date signad (Month, Dey, Y							
	5		1000	Dp	ty Med Ex	K D O	9157		i i	April 16	200	טט					
	2		30. Name and address of person who o	omplated causa of death	(Itam 23a) (Type,	Print)											
	nds		Paul Snow, M.D.	124W 3rd S	T Cumb M	21502						-					
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State of Maryland / Department of Health and Mental Hygiene

			Otato or in	ar y larre			f Death		Reg. No.		+ /49
Physic /Med		1. Decedent'a Name (First, Middle, La Chester N	Martin	M	Miller		Jr.	2. Date of Dea Month		Yeer O	3. Time of Death 2:35 pm
Exam		4e Facility Name (If not institution, give	re street end number)		,		4b. City, Town, or I				
Funera Director	_	Memorial Hospit 5. Social Security Number 213-22-2889		ge (In yrs. la 71		Under 1 Year onths Day			Alle 1. Yeer) 192		ce (State or Foreig
P.		Usual Residence of Decedent		140.00	_						
show	ector	10e. State 10b. County MD Garre	\++	TUC. City,	Town or Location. Grant		1.0			100	<ul><li>d. Inside City Limits</li><li>1 ☐ Yes ☆ ☐ No</li></ul>
the N		10e. Street end Number				Of. Zip Code			10g. Citizen of V	Mhat Count	
ter death with the Marylan itams 23a or 28s-f show that must be notified at	Funeral Director	847 Meyersdale					21536		USA		
B 9 E	by	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Tes 2 Hes, Give Center or Detection	No		Yes 2 N	f Hispanic Origin? (S uban, Mexican, Puerl to <i>Specify:</i>	o Rican, etc.)		a - America ck, White, e whit	tc.
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wild be file Mentel Hy srked oth	4)	17. Fether's Neme (First, Middle, Last)  Chester M. Miller. Sr.  18. Mother's Neme (First, Middle, Meiden Sumeme)  Juanita (Sharon)									
d 2 sho th and 7 is me traum		19a. tnformant's Name/Relationship (Nancy J. Miller	Type, Print)	8	19b. Mailing A. 47 Mey	ddress (Stre	et and Number or Ru ale Road	Grants	er, City or Town, SVILLE	State, Zip (	21536
Peges 1 ent of He nt: If iten y or oth		Wife  20a Method of Disposition  ↑□ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specia		Ce	ace of Disposition metery, cremeto	ry or other p	lal Gard	Date	20c. Location -		
permit. Pe Departmen Important: any Injury		21. Signature of Funeral Service Licer		sols	Set	Tye 1	ind, MD	al Home	LaVale P.A.	e, MID	
DI!!		23a. Part1. Enter the diseese, or com shock, or heart tailure. List only.	plications that cause one cause on each li	d tris death ine.	Do not enter th	e mode of d	ying, such as cardia	or respiretory a	rest,		Approximate Intervat Between Onset and Death
Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a ACUT				L INFA	RCTION	)	4	3 DAYS
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cate be executed physician end s the buriel-transit	Medical Examiner	edical	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b							
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he law requiras that the death cele has been signed by the attendir		VIAIDOLES	MELLITU	3					an autopsy rmed?	avai	re autopsy findings lable prior to apletion of cause
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To the Hospital of within 24 hours a To the Funeral D completely filled it	edical (		nysician: To the best niner: On the basis o and manner st	f examinelie							
To th To th comp	Me	29b. Signature and title of certifier	0 1		0	29c. Lice	nse number		29d. Date signe	d (Month, D	Pey, Year)
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The	28	Dr. R. Barrera, M	/				do. Cumba	rland 1	MD 2150	12	
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State of Maryland / Department of Health and Mental Hygiene 4750 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day Month **Physician** HAZEL E. McCRAY APRIL 13, 2000 3:25 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN If Under 24 Hrs. WORCESTER Birthplece (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer) **Funeral** Deys 1 M 2 TxF 60 Yrs Director 221-26-4693 2/5/1940 DELAWARE Usual Residence of Decedent death with the Marylend 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mantal Hygiena. Important: if Item 27 is marked other than "natural, or items 23s or 28s-1 show any Injury or other traumstic event, I'm Medical Examinal must be notified as 1 ☐ Yes 2 No Director DELAWARE SUSSEX FRANKFORD 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? RT. 2 BOX 292 19945 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Yes 2 No If Yas, Give Yeer or Dates: 1 X Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER HOME MAKING 11 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fether's Name (First, Middle, Lest) Be VIRGIL D. McCRAY SR. **ELIZABETH STURGIS** 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) PATRICIA McCRAY - DAUGHTER RT. 2 BOX 292, FRANKFORD, DE 19945 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, Stete 4 ☐ Donetion 5 ☐ Other (Specify) ANTIOCH CEMETERY 4/18/00 FRANKFORD, DE 21. Signature of Funerel Service Licensee 22. Name and Address of Facility WATSON FUNERAL HOME, INC. Jatson Nechar MILLSBORO, DE 19966 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical Examiner Examiner physician end the burial-transit certificata be axecuted Sequentially list conditions, if eny, laading to immediate ceuse. Entar Underlying Causa (Disaasa or injury Due to (or es e consequence of) Records, P.O. Box 68760, attending physician I for use es the buria Physician/Medical thet initiated evants resulting in death) Lest Due to (or es e consequence of) ed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b by cate hes been sig page 2 should b 24b. Ware eutopsy findings eveitable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed 2 No 1 Tyes 1 ☐ Yes 2 ☐ No certificate Be 25. Was casa ratarred to medical 26. Placa of Daath (Check only ona) examiner? Hospital: 16 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 yes 2 No 2 ER/Outpatient 3 DOA 27. Marinar of D funeral nar of Death Data of Injury (Month, Day Year) 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after daeth.
 Funeral Director: After th Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation Injury To the Hospital or Attendir within 24 hours after daeth.
To the Funeral Director: Al complately filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida to the best of my knowladge, daath occurred at tha tima, data and placa, and dua to the ceusa(s) end menner as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred et the time, date and placa, and dua to tha causa(s) end menner stated. Medicai 29a. Certifier 29d. Pate signed (Month, Dey, Year) 29b. Signature and title of 29c. License number Hesthury Pr Borein MD 21811

32 Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

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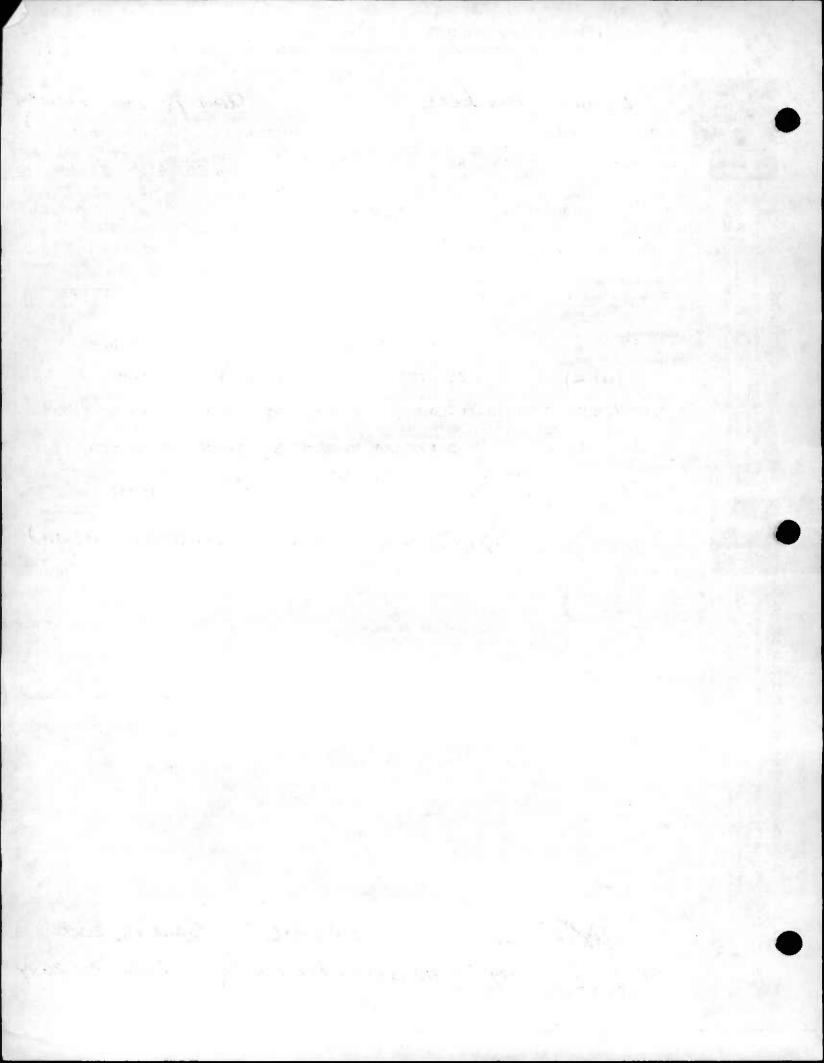
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month / Mackell 12:20 PM Louise 15 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Death 4b. City, Town, or Locetion of Deeth Examiner VANTAGE HOUSE COLUMBIA HOWARD 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □ MF 85 212-30-2129 Yrs. Director MAR 30,1915 FRANCE Usual Residence of Decedent 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD HOWARD COLUMBIA Y☐ Yes 2☐ No 10e. Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 5400 VANTAGE POINT ROAD 21045 Funeral FRANCE 12. Was Dacedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or heavy injury or other traumatic event Bleck, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify. WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 1 2 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK) SOLLIER (UNK) CONAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 222 21stSTREET, STONE HARBOR, NJ 08247 JAMES MACKELL/BROTHER-IN-LAW 20b. Plece of Disposition (Neme of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GREENWOOD MENNONITE 4/18/00 GREENWOOD, DE 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Sarvica Licens 22. Nama and Address of Fecility
FLEISCHAUER FUNERAL HOME POB 502, GREENWOOD, DE 19950 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** ne has taxic Breast Careivalus Immediate Ceuse (Final disaese or condition resulting in deeth) /Medical Mastas Examiner Examiner physician end s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In daeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of) been signed by the should be detached Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? cate hes l 20 No certificate 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physician: To sefter death.

Il Director: After this certificat ed in by the funeral director, pa 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Yeer) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled in edicai 29a, Certifier 1 🗲 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifie 29c. Licansa number Mos 30. Name end address of person who completed ceusa of death (Item 23e) (Typa, Print) LEVINE, LD, 11055 Little PATCIKENT Pley, Columbs, My 21044 32 Amistrar's Signature State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14752 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death TPALL anoke 2000 4b. City, Town, or Location of Death 4e Facility Name (If no institution, give street end number 4c. County of Death thdey) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. AMBRIDGE 5000 )ectes pen 7. Age (In yrs. last birthdey) 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 10 M 200 F 220-32-883 Usuel Residence of Decedent 220-32 5 March 241 Mary 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Madison 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Marsh 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 2 No Specify. Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Health Aide 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Keene Lee James Nartha 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) White Marsh Road Madison, Maryland tion (Name of Date 20c. Location - City or Town, Etate 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State Cemetery 01/2000 Hurlock, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facilities FUNERa HENRY 510 Washington 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death as cerdiac or respiretory errest, Immediate Cause (Final disease or condition resulting in death) caused by execeptation hurs. d'Ecan Obstructie Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Discon years HERVA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 → bnknown Markell Dhaoita

Physician /Medical Examiner

Box 68760

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

10a. Stete

Funeral Director

Be Completed by

**Funéral** 

Director

Physician/Medical Examiner Medical Certification: To Be Completed by To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certified completely filled in by the funeral director; I

101010	isa.				1			
	0	24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of ceuse of deeth?					
				1 ☐ Yes 2 No	1 □ Yes 2 No			
25. Wes cese referred to medical		11	26. Plece of De	eth (Check only one)				
examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3□ DOA	lome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 Seturel 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, fectory,	281. Location (Street end Number or Rurel Route Number, City or Town, Stete)					

15 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. 29c. License number

State Registrar

NOMAN THANWY 31. Date filed (Month, Day, Year)

APR 2 5 2000

29b. Signature end title of certifier

29a. Certifier

300 AURORA STREET 32. Registrar's Signature

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

47924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

MD 21613

4.22-200

AFR 2 5 2000 James B. Konth

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 26 per phys. G784 6/19/00 yg Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day Yaar Month **Physician** 5:45 pm GEORGE MIDDLETON 20, 2000 4c. County of Death 4b. City, Town, or Location of Death /Medical 4a Fecility Nama (If not institution, give street and number) Examiner 216 Pine Cove Lane Chestertown Queen Anne If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Days Hours Months 1**∑** M 2□ F Yrs 101 Director 171-10-9425 7-1-1898 Maryland Usual Rasidance of Deceda 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ntal Hygiene. ed other than "naturel", or items 23a or 28e-f show event, the Medical Examinor must be notified at the Maryla 1 ☐ Yas 2 ☑ No Delaware New Castle Smyrna Director 10e. Street and Number 10f. Zip Code 10g. Citizan ot What Country? 588 Massey 19977 USA Church Rd. Funeral Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Raca - Amarican Indian, Black, White, atc. 11. Maritel Status lied within 72 hours after 1 Nevar Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify.white á 3 ☐Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Oil Refinery Supervisor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if flem 27 is mented other any injury or other two 17, Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) 8 H. Middleton E. Cahall James Margaret 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 588 Massey Church Rd., Smyrna, DE. 19977 Morris Carl 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Buriat 2 Cramation 3 Removel from Stata 4 Donation 5 Othar (Specify) Townsend Cemetery 4-26-00 Townsend, DE. 21. Signature of Funaral Sarvice Licen 22. Nama and Addrass of Facilit DANIELS & HUTCHISON FUNERAL HOME 212 N. Lu Broad st., Middletown, DE. 19709 Approximata Intarval Batween Onsat and Daath 23a. Part1. Enter the disease, or complications and caused the cleath. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on the complete the comple Physician wee /Medical Immediata Causa (Final y ear disaasa or condition rasulting in daath) Examiner Dua to (or as a consequ nce of): MANY Examiner P /dur ú. Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last and Dua to (or es e consequance of) Physician/Medical Dua to (or as a consequanca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 94 signed by t Yes 2 No 3 Probably 4 Unknown à Records. 24b. Wara autopsy tindings available prior to completion of cause ot death? should should 24a. Was an autopsy performed? Completed page 2 has 1 Yas 1 ☐ Yas 2 ☐ No certificate Division of Vital Be 25. Was casa ratarred to medical examinar? 26. Placa of Death (Check only ona) asstist.living Other: 4₩ Nursing Home 5 ☐ Rasidence 6 DOther (Specify)Rest. Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Athar 5 Panding 1 Neturel 2 Accident death. 1 Yes 2 No invastigation after death Director: 6 Could not be detarmined 3 Suicida 28e. Place of Injury - At homa, ferm, street, factory, office building, afc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida e Hospital or 124 hours aft e Funeral Di letely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifiar completely (Check only Within 2 To the 3 29b. Signaty a and titla of certifian 29d. Data signed (Month, Day, Year) 29c. Licanse number

Registrar

W

State

30. Nama and addrass of parson who completad

APR 24 2000

Wayne Benjamin,

31. Data tiled (Month, Day, Year)

6602 Church Hill Rd., Chestertown, Md. 21620

causa of daath (Item 23a) (Type, Print)

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16756 Amended #26, 4/28/00, cwc, Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Howard R Newnam Jr 2000 April 25 1918 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Funeral Months Days Hours 215-44-5772 53 Yrs 04-26-1946 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Tes 2 No Director mo KENT CHESTERTOWN 10e. Street and Number 10g. Citizen of What Country? ò 23a 6157 TolchEster Rd. USA 21620 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Proof If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 20 No Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bram blers Co. 9 th CONSTRUCTION **Baltlmore, Maryland** 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked oth any Injury or other treumatic event anse. 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD HEWNAM, ST. MATTIE LIVELY 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Roger New Man (Brother) 6/37 /0/c/re20b. Place of Disposition (Name of cemetery, crematory or other place) Tolches TERRA, Chester Lawy, md. 2/620 20a. Method of Disposition CHESTER TOWN, ynd. 4 ☐ Donation 5 ☐ Other (Specify) 4.29.00 JOSHUA 4.M. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WALLEY FUNERAL SETVICE-CHESTERTOWN, MD21626 23a. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or helant feliure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 6 Wester CULOS DUF HUMT FINEUNC Examiner Due to (or as a consequence of): Physician/Medical Examiner Hyrun rusius 10 yours The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien and for use as the burial-tren. Due to (or es a consequence of) Box 68760. Due to (or as a consequenca of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? funeral director, page 2 ahould Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificata 1 Tes of Vital for Attending Physicien: "
after death.
Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home -6 Thesidence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident illed in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical To the Hosp within 24 hou To the Funer completely fil 29a. Certifier (Check only one) 29b. Signature and title of certifip 29c. License number 29d. Date signed (Month, Dey, Year) 1)0013824 4-26.00 my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

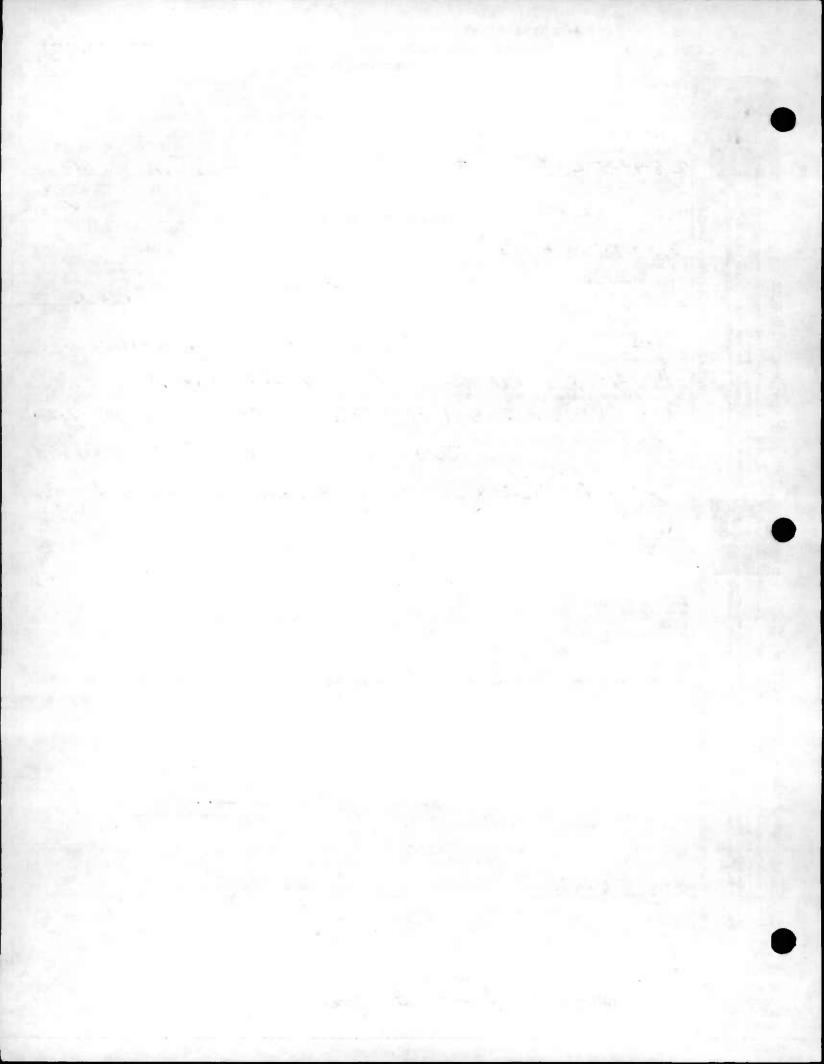
TO HNC. SEYMOUR

APR 28 2000

31. Date filed (Month, Day, Year)

32. Registrer's Signature

122 SPEER Rd. CHRSTER TOWN, md. 21620



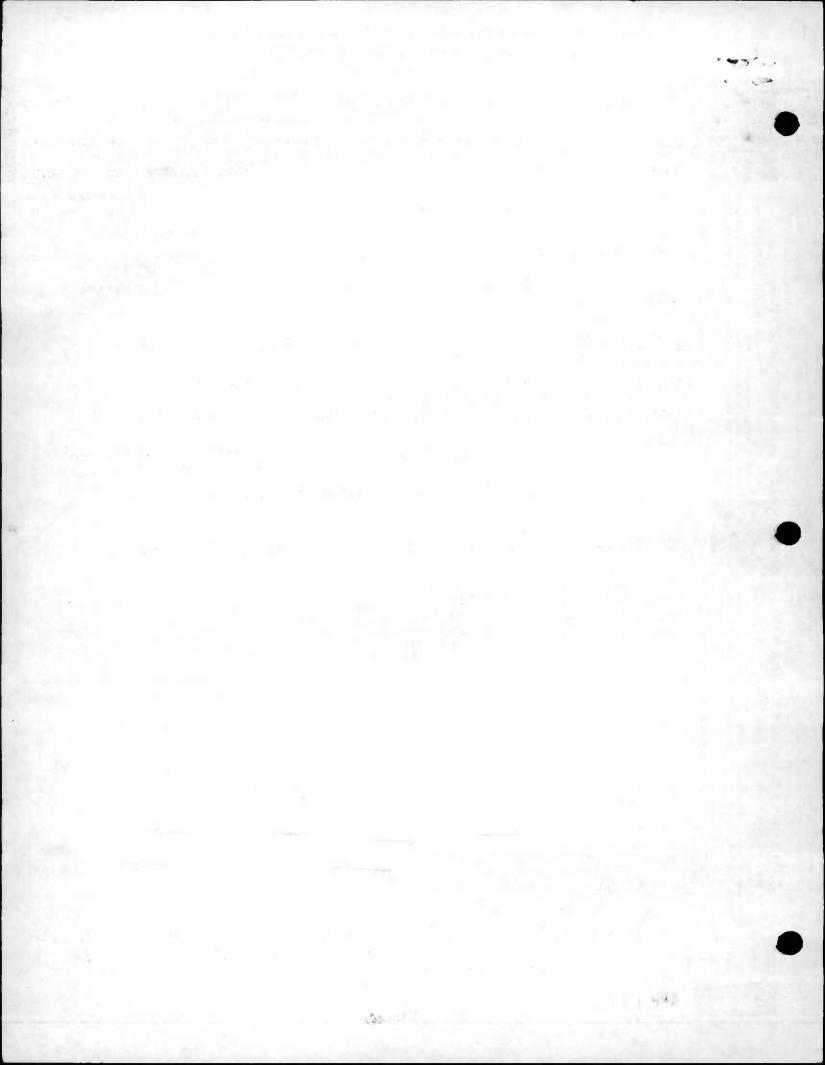
State of Maryland / Department of Health and Mental Hygiene

cian dical	1. Decedent's Name (Fir	rst, Middle, La	ist)					Date of Death Month	Dey	Yeer 3.	Time of Death	
alcui :	Andrew	Κe	evin Ne	ewman.	II			PRIL 4			:30 A.M.	
iner	4e Facility Name (If not	institution, giv	ra street and number)			4b. City,	Town, or Location	on of Death	4c. County	of Death		
	WOODED AREA	OFF C	LD HERMANV	LLE RO	AD	PARK	HALL		ST.	MARY'S		
	5. Social Security Number 231-61-161	10	Sex 7. Age 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	(In yrs. lest birt	hdey) If Under Months	r 1 Year   If Und Days Hour		Date of Birth (Month, Dey, 1y 14,	Year) 1984 }	9. Birthplece Country)	(State or Foreign lary land	
-	Usual Residence of Deci	edent . County		10c. City, Town	or Location					104 1	nside City Limits	
5											Yes 2 No	
20	Maryland  10e. Street and Number	St. M	lary's	Lex	ington ]							
Funeral Directo		0-			10f. Zip		F 2			What Country?		
	20224 Spitf	ire Co	12. Was Decedent Ev	rer in II C	12 Was Dasse	206				States e - American In		
	11. Marital Status  1 Never Married  3 Widowed 4 1		Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedant of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexicen, Puerto  1□ Yes 2■ No Specify:				Blac	ck, White, etc.  : White		
	15. I	Decedent's E	ducetion ade completed)	16a.	Decedent's Usu:	al Occupation	ost of working	1	6b. Kind of Bu	usiness/Industr	/	
-	Elementary/Secondary		College (1-4or 5+)		life. DO NOT u	ork done during m se retired)		-				
Completed	10				Student				High S			
	17. Father's Neme (First,	, Middle, Last	)			18. Mo	ther's Name (Fi	irst, Middle, M	laiden Sumem	10)		
	Andrew K	Cevin N	lewman			Sa	mantha	Carmen	Richar	rds		
1	19a. Informant's Name/F	Relationship (	Type, Print)	19b.	Mailing Address	s (Street end Nur					e)	
Andrew Kevin Newman / Father 20224 Spitfire Court, Lexington Park, MI											0653	
ŀ	20a. Method of Disposition			20b. Place of	Disposition (Ne	me of				City or Town,		
			Ramoval from Stata		y, cremetory or o							
-	4 Donation 5		71	Charle		ial Gard		0-00 L	eonardi	town, M	aryland	
any injury or pace.	21. Signature of Funeral	Service Lice	30/1		22. Name ar	nd Address of Fa	Brins	field	Funeral	1 Home,	P.A.	
ı	SC CO	Reins	field ar	100052	22955 1	Hollywoo						
+	23a. Part1. Enter the dis	sease, or com	plications that caused th	ne death. Do n	ot enter the mod	da of dying, such	as cardiac or re	spiratory arre	st,	App	roximate	
	shock, or heart feil	ure. List only	one cause on each line								rvel Between set and Death	
	Immediate Cause /Final		0 1			0.1						
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	resuling in death)				onsequence of):							
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			a sauth rate of a datable book	not resulting in	the underhiles	rause niven in De	art I.	23b. Dld tol	oacco uae cor	ntribute to the	cause of death	
	Part II. Other significant	conditions	contributing to death but	not rosuming in	the underlying c	zauso givori iri i		23b. Did tobacco use contribute to the cause of deat				
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	Part II. Other significant	conditions	contributing to death but	, in the state of	the underlying c	Sauso given in re		1 🗆 Ye	8 2× No			
	Part II. Other significant	conditions	contributing to death but		the underlying c	auso given ii i i		24a. Was ar	autopsy	24b. Were a	utopsy findings le prior to	
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	Part II. Other significant	conditions of	contributing to death out	Total Total Ing In	the underlying c	acuse given in re		24a. Was ar perform	autopsy ned?	24b. Were a availab comple of deatl	utopsy findings le prior to tion of ceuse	
			contributing to death but		the underlying c			24a. Was ar perform	autopsy ned?	24b. Were a availab comple	utopsy findings le prior to tion of ceuse	
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	25. Was cese referred to axaminar?  1⊠ Yes 2 □ No  27. Manner of Death 1 □ Natural 5 □ 2 □ Accidant	medical  Pending investigation	Hospitel: 1 Inpatient  28a. Date of Injury (Month, Day)	: 2 ER/Ov	tpatient 3□ D0	26. Pl	Nursing Home 28d	24a. Was ar perform Ye Ye Check only one	autopsy ned?  s 2 □ No  a)  nce 6 XXOth	24b. Were a availab comple of death	utopsy findings le prior to tion of ceuse n? s 2 \( \text{No} \)	
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APR 6 2 2001 James 12 April 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#28a-28f perPhyG784 6/21/2000 EW Certificate of Death Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death AN DREW **Physician** 2000 43 PH /Medical 4e. Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Lape Nunsing Center Laure MD PRINCE GROGES TERRY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months 10 M 20 F Deys Hours Director 239-12-8135 FEB. 19,1920 NORTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural; or items 23s or 28a-f show other traumatic event, the Medical Examiner roust be notified at 10d. Inside City Limits Director MD PRINCE GEORGES LAUREL TV Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14707 BOWIE RD. APT.#102 20708 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? XIXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes Ž**O**XNo Specify. BLACK by Specify: ¾XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiane Important. If item 27 is marked other than any injury or other traumatic avens. Elementery/Secondary (0-12) College (1-4or 5+) 8th GRADE SPECIAL POLICEMAN GOVERNMENT 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) JAMES NEWKIRK LULA MC ALLISTER 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BARBARA DAVIS DAUGHTER 14707 BOWIE RD. APT.#102, LAUREL, MD. 20708 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) ROSE HILL CEMETERY 4/16/2000 MAGNOLIA, N.C. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility JOHNSON & JENKINS, INC. 716 KENNEDY ST. N.W., W.D.C. 23e. Pert i enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting In death) /Medical Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. been signed by the should be datached 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? page 2 should Completed 24a. Was en eutopsy performed? certificata has 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) Be Hospital: Other: Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Rey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Naturel 5 Pending after death. Director: Aft 1 ☐ Yes VV 2 Accident investigetion M 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide whin 24 hou.
To the Funeral Dr.
Satoly filled in 29a. Certifier Medical ertifying Phyeiclen: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner whited. 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Yeer) eddress of person who completed cause of death (Item 23e) (Type, Print) ALUDHU APR 1 9 2000 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year Physician **JESSIE** LEE HORNER OVERTON 2000 5 PRIL 1850 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth Examiner SALISBURY PENINSULA REGIONAL MEDICAL CENTER WICOMICO If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foraign Country) 6. Sax **Funeral** 1□M 2QF Months Days Hours 214-28-8604 Yrs. Director 68 January 7,1932 Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits **ehow** 1 ☐ Yas 2 X No Director Maryland Wicomico Salisbury r than "natural", or itema 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 414 Pine Bluff Rd. 21801 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14 Raca - American Indian Black, White, etc. 1 Never Merried 2 Married White Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working tife. DO NOT use retired) Wicomico County Board Elementary/Secondary (0-12) College (1-4or 5+) School Teacher of Education 12 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) 12 should be fill hend Mentel H Reese Lowe Horner Mary Lee Foreman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 to Department of Hasith er Important: if Item 27 to eny Injury or other treu 414 Pine Bluff Rd., Salisbury, MD 21801 Levin R. Overton/Husband 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location · City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 4/19/00 Salisbury, MD 22. Nanga and Addrass of Facility Holloway Funeral Home Professional Association nature of Funeral Service Licenses M01051 Ovida 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Physician Immediata Cause (Final disease or condition resulting in death) /Medical liver cirhos mm ansonce Examiner Due to (or as a consequence of): physicien and s the burlel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of deeth? s certificate hes t 2)X(No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Be Medical Certification: To Hospital: 112 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No investigetion 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to tha cause(s) end mennar es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner steted. (Check only one)

Registrar **DHMH 16 Rev 6/95** 

State

29b. Signature and title of certifier

Dr. Joseph Badros

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4098

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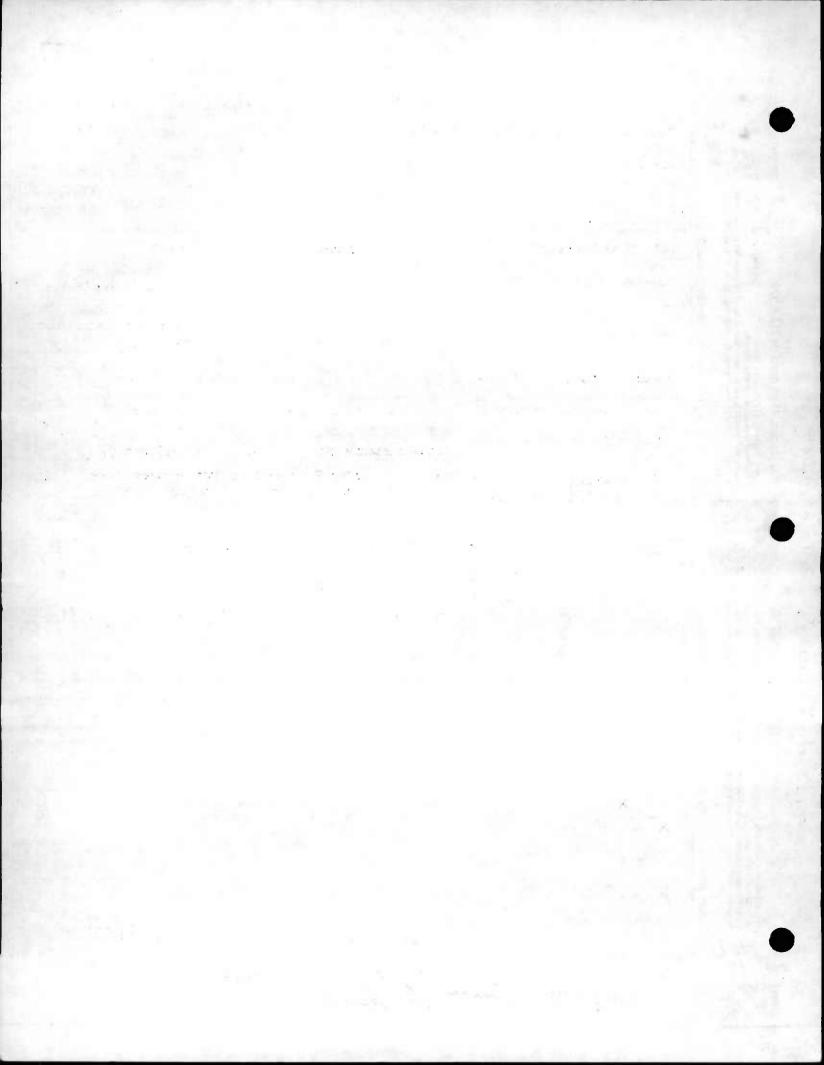
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29c. License number

813B Eastern Shore Dr., Salisbury, MD

29d. Date signed (Month, Day, Year)

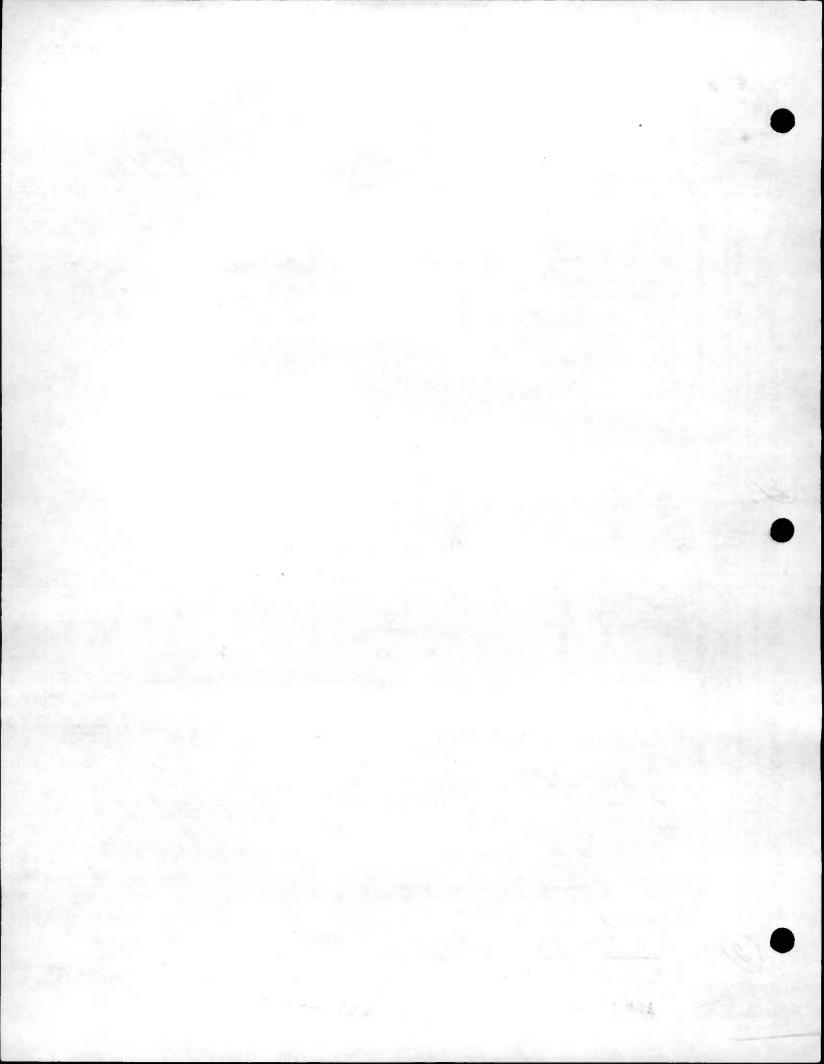
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Daath Month Dey Joseph Popp 2000 9:30 am April 17, 4a Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Memorial Hospital Cumberland Allegany If Under 24 Hrs. 8. Date of Birth Hours Min. DeC 5, Year) 36 If Under 1 Yeer Months Deys 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foraign Country) 1 M 2□ F 218-34-4602 63 Yrs. Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Yes 2 No MD Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g. Citizen of Wher Country? 12350 Williams Road 21502 USA 12. Wes Decedent Ever in U,S. Arroed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 9 5 6 - 7 9 Yeer or Detes. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, 11 Marital Status Bleck. White, etc. Never Merried 2 Married 1 ☐ Yas 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Retired U.S. Air Force 18. Mother's Name (First, Middla, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) William M. Popp Violet (Duckworth) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)
12350 Williams Road; Cumberland MD 21502 19a. Informant's Name/Reletionship (Type, Print)
V. Marlene Popp Sister 20a\_Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Method of Disposition

Buriat 2 Cremetion 3 Removel from State Date 20c Location - City or Town State 4 ☐ Donetion 5 ☐ Other (Specify) Sunset Memorial Park 4/20/ Cumberland, MD Scarpeli's Fulleral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, of conshock, or heart faiture. List only Approximete Interval Betwean Onset end Death Do not antar tha moda of dying, such as cerdiac or respiratory errest, Immediata Causa (Final disaasa or condition resulting in daeth) Myocardial Infarction 2 weeks Due to (or es e consequence of): Diabetes Mellitus 15 years Sequentially list conditions, if eny, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Dua to (or as e consequance of): Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 🗆 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examinar? 26. Placa of Daath (Check only ona) Hospitel: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

2

**Funeral** 

Director

worde

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with the Maryland

death

e filed within 72 hours after all Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ia marked other any Injury or other traumatic avanta

Maryland 21215-0020

altimore,

Examiner Physician/Medical

physician and s the burial-transit as 980 for page 2 funeral director, the In by

certificate be executed P.O. 节 6 signed b of Vital Records, Deen certificate has this Division I or Attending after death. I Director: Aft 24 hours at Funeral D filled complataly within 2 To the

þ Completed 8 2 Certification: edical

5

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and mannar es steted.
2 Examiner: On the basis of axaminetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. 29b. Signature and fittle of certif

5 Pending investigation

6 Could not be

D36766

29c. License number

28c. tnjury et Work?

1 Yas 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Dascribe how injury occurred

18 April 2000

30. Nama and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

920 Natioanl Highway V. Poonai, LaVale, MD

State Registrar

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32 Registrar's Signeture

28b. Time of Injury

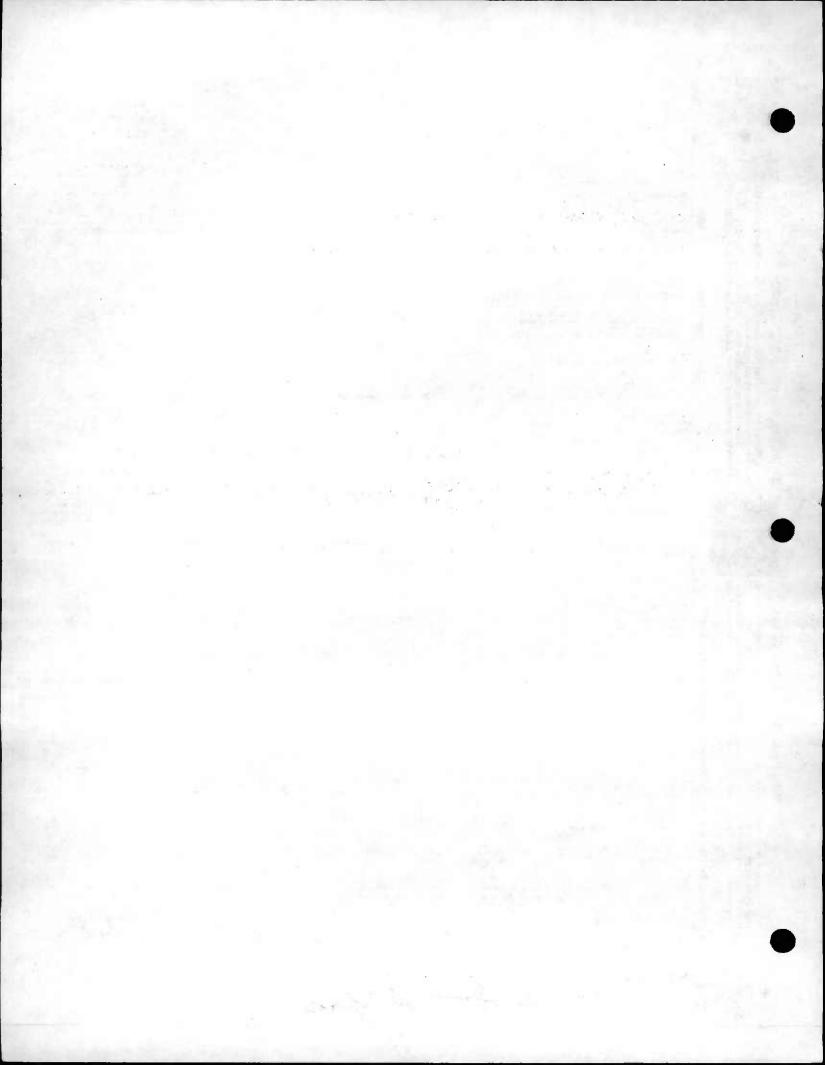
28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

APR 2 0 2000 Seem

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 4760

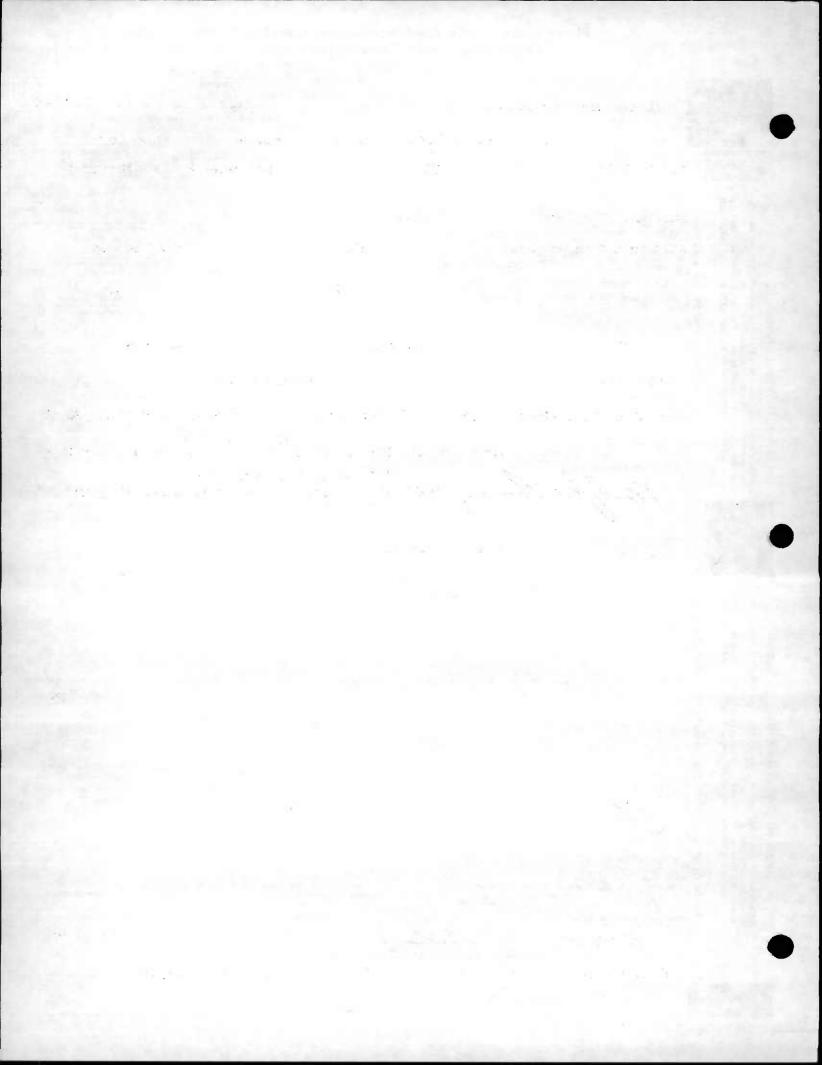
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		1. Decedent's Nama (First, Middle, Las	t)				2. Data of Death	1		. Tima of Death				
_	Physician /Medical	FRANCES HI	JFFMAN	PUSE	EY		Month	Day 2	Year	0745				
	Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or	Location of Death	4c. County	of Death					
101		PENINSULA REGION	NAL MEDICAL C	ENTER		SALIS	BURY	WI	COMICO					
	Funeral	Social Security Number     6. Security Number		s. last birthday)	If Under 1 Year Months Days			Year)	9. Birthplace	(State or Foreign				
	Director	212-40-0032	□M 2X7F 96	Yrs.			(Month, Day, FEB. 25	, 1904	MARYLA	ND				
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	or 28s-f s be notified Director	MARYLAND WICOMICO	)	SALISBU			4/	Og. Citizen of V						
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320	or a should be brind within 72 hours after death with the maryland th and Montal Hyglans.  The marked other than "natural", or hems 23a or 28a-f show traumatic avent, the Medical Examinat must be notified at To Be Completed by Funeral Director.	3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva		1 ☐ Yas 2 ☑ No	Specify:		Specify	" WHI	re				
Ď į	De la la la la la la la la la la la la la	15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occu	pation		6b. Kind of Bu						
21215-0020	yglene. Ne then "naturn it, the Medical.	(Specify only highest grad Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking							
21	and the	12	2	DEPU	JTY CLERK			COURT	OFFICE	E				
פ	d other avant.	17. Father's Nama (First, Middle, Last)				18. Mothar's Na	ma (First, Middle, N	laiden Sumam	(e)					
<u>a</u>	Mental Mental Mental	JOHN M. HUFFMAN				MARTHA	BURGOYNE		Sity or Town, Stata, Zip Code) MD 21863 c. Location - City or Town, Stata SNOW HILL, MARYLAND 705 E. MAIN ST. SALISBURY, MD 21804 Approximata Intarval Batween Onsat and Death					
Maryland	and Men and Men and Men	19a. Informant's Name/Ralationship (7)	ype, Print)	19b. Mailin	ng Addrass (Stree	t and Number or A	ural Route Number,	City or Town,	Stata, Zip Coo	de)				
- 4	end 2 beith a n 27 la er tra	DOT WILSON - NIEC	E	114 1	CRONSHIRE	E ST S	NOW HILL,	MD 21	863					
യ -	- 7 5 5	20a. Mathod of Disposition		Place of Dispo	sition (Name of matory or other pla	ice)	Data 2	20c. Location -	City or Town,	Stata				
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Balt	Depertment Depertment Important: I any Injury o	21 Signature of Funeral Service Licenses 22 Name and Address of Facility												
<b>n</b> 3	SEES	Malessula	us House	1	ROUNDS FU	NERAL HO	ME INC							
		23a. Part1. Entar the disease, or comp shock, or heart tailura. List only	ncations that caused the						Api	proximata				
P	hysician	snock, or neart tailura. List only o	ne cause on each ing											
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-	ng physicien and as the burlatransit	Sequentially list conditions.												
5	EX A	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying												
68760,	ysici he bu	Cause (Disease or injury that initiated events resulting in death) Last	cDua to (	or as a conseq	uence of):									
õ	Med	Tosoking wi doadii) Last												
. BOX			d						1					
	d by the attend letached for us	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying ceusa gi	ven in Part I.	23b. Did to	bacco use cor	ntribute to the	cause of death?				
י ס	Phy tach						1 □ Ye	s 2□ No	3 Probabi	ly 4 Unknown				
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Hecords, P.O.	cate has been signed, page 2 should be c						24a. Was ar			autopsy findings ole prior to				
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I g	te has bege 2						1 □ Ya	s 2 No	1 UY	as 2 No				
= '	- C	25. Was casa refarred to medical				26. Place of De	ath (Check only one	9)						
or Vital Records,	his cer il direc	axaminer? 1 ☐ Yes 2 ☐ No	Hospital: 1 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ot	hor-	Homa 5□ Raside		ar (Specify)					
	er thi	27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima o	28c. Inju	ry at	28d. Dascribe ho	w injury occurr	red					
VISION	eeth. for: After the fune cation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident invastigation	(Month, Day rear)	Injury		Yas 2 No								
DIVISION	ofter deet Director: I in by the	3 Suicide 8 Could not be detarmined	28a. Place of Injury - At I	homa, farm, str	reet, factory, office		28f. Location (Str City or Town		er or Rural Ro	oute Number,				
בֿ בֿ	al Director. After the in by the funeral Certification:	4 D Tollicos	building, atc. (Spec	ary)			Ony or Your	, State)						
Hoenitei			sician: To the best of my kn											
3	n 24 hound he Funer pletely fii edical	(Check only 2 Medical Exami	ner: On the basis of axamin and manner stated.	ation and/or in	vastigation, in my	opinion, daath occ	urred at tha tima, de	ita and place,	and dua to the	ı causa(s)				
Tothe	within To the company of the company	29b. Signature and title of certifier	200	0	29c. Licen			d. Data signe	d (Month, Day	Year)				
	0	Com	7/5/ M/		05	0759		4/2	0/00	3				
	ZIM	30. Nama and addrass of person who c	ompleted causa of death (tte	m 23a) (Type,	D 1.43				1					
	0	CHARLES D.	to CASTIA	DE!	NO, 10	8 KIN	EBLUFF	- KD	JA415	BURY ML				
	State	31. Data filed (Month, Day, Year)	100 32. Rangemar's Sign	natura /	1				-					
	Registrar	HTK & U ZI	100	10	· done	1.1								



State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** April 23 2000 2:05AM Elaine Marion Posev /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva straat and number) 4c. County of Death Examiner Charles County Nursing Rehab Center La Plata Charles If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Yaar)
September 8, 1 7. Age (In yrs. last birthday) If Under 1 Yaar 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Deys 1 M XXF Yrs 1926 Maryland Director 220-16-7797 73 Usual Rasidenca of Decedant with the Marylend 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Modical Examinar must be notified at 1 ☐ Yas 2 No Directo Maryland Charles Nanjemoy 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 4570 Port Tobacco Road 20662 United States Funeral deeth 12. Was Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours effer d Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exerci-Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Give Yaar or Datas: X Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: þ **Black** 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Her Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Be Oscar Posey Nellie Lawson 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Deborah C. Posey-Thomas/Niece 4570 Port Tobacco Road, Nanjemoy, Maryland 20662 200. Location - City or Town, Stata 20b. Placa of Disposition (Neme of camatary, crametory or other place) 20a. Mathod of Disposition April 26, 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 4 ☐ Donetion 5 ☐ Othar (Spacify) Church of the Lord Jesus Christ Ironsides, Maryland 22. Nama and Addrass of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral S M00668 4270 Hawthorne Road, Indian Head, Maryland 20640 e, or complications that caused ha daeth. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, List only one cause on each hea. Approximata Intarval Batwaen Onsat and Death **Physician** /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Ovarian Cancer Examiner Due to (or as a consequence of): Examiner requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Ceuse (Disaase or Injury that initiated events resulting in daath) Last physicien end s the buriel-tren Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequance of) 9 950 been signed by the should be deteched Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to tha cause of death? 1 Yes 2 No 3 Probably 42 Unknown Records, þ 24b. Wara autopsy findings evailabla prior to complation of cause of death? Completed 24e. Was en eutopsy performad? pege 2 hes 2XXIIO 1 □ Yas 2 □ No 1 ☐ Yas this certificate Division of Vital or Attending Physician: funeral director, Be 25. Was cese refarred to medical axaminer? 26. Plece of Deeth (Check only ona) Hospital: 1 Inpatiant Other: STANUTSING Home 5 Rasidance 6 Other (Specify) 1 ☐ Yas XXNo Certification: To 2 ER/Outpatiant 3 DOA 28e. Data of Injury (Month, Day Year) 28c. Injury et Work? 28b. Tima of 28d. Dascribe how injury occurred 27. Mannar of Death After Naturel 2 Accident 5 Panding Injury 1 Yas 2 No 24 hours efter death. Invastigation 6 Could not ba dataminad 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital XXcertifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) and manner es steted. 29a, Cartifian Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) within 2 To the 1 the 29d, Data signad (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licensa number 0 D28352 April 24, 2000 30. Nama and addrass of parson who complated causa of daath (Itam 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

APR 26 2000



State of Maryland / Department of Health and Mental Hygiene

ene 00 14762

			Ce	rtificate c	f Death		Reg. I	No.					
	1. Decedent's Name (First, Middle, Las	()					Date of Death		Year	3. Time of Death			
Physician /Modical	WILLARD THOMAS	RUNNER					pril 18	Day , 2000		7:27 pm			
<ul><li>/Medical Examiner</li></ul>	4a Facility Nama (If not institution, giva	street and number)			4b. City, To	wn, or Location		4c. County		, , , , , , , , , , , , , , , , , , ,			
	302 COLUMBIA STRE	ET			CUMBE	ERLAND		ALL	EGANY				
ineral					ar If Under		Date of Birth (Month, Day, Ye	ar)	9. Birthplac	e (State or Foreig			
ector	232-66-1614 Usual Residence of Decedent	XM 2□ F 57	Yrs.	Months De	ys Hours		JLY 25 1		Country	W.VA.			
unt be notified at rai Director	MARYLAND 10b. County ALLEGA		CUMBER						10d	. fnside City Limit 1 XYes 2 N			
be notified Director	10e. Street and Number			10f. Zip Cod	е		10g.	Citizen of W	hat Country	7			
a le	302 COLUMBIA STREE	T		215	02		U	J.S.A.					
Evantrar or by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Evar in I Armed Forces? **XYes 2 No If Yes, Give U.S.A Year or Dates:		Was Decedent of If Yas, specify C	uban, Mexicar	gin? (Specify i, Puerto Rica	Yes or No- in, etc.)		American k, White, etc	o			
f, the Medical	15. Decedent's Ed	ucation		dent's Usual Oc		t of unrking	16b	. Kind of Bu	siness/Indus	stry			
aldr eldr	(Specify only highest grad Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)	or working							
Com	11		SHEID	OW BRON	ZE CO.		MA	RKERS	/BRON	ZE			
Be (	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (Fi	rst, Middle, Maid	den Sumami	a)				
To	FREEMAN WILLARD RU	INNER			LENOF	RA SIGI	LEY						
5	19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	ng Address (Str	eet and Numbe	er or Rural Ro	oute Number, Ci	ty or Town,	State, Zip C	ode)			
injury or other t B.	DIANA LYNN LEWIS  20a. Method of Disposition  1 Burial 2 CCremation 3 1  4 Donation 5 Other (Specify	Removal from State	Place of Dispo cam <i>etery, cre</i>	BOX#51 position (Name of matory or other) D CREMA	place)		ate 20c	. Location -		n, State MARYLAND			
any injury or	21. Signature of Funeral Service, Licans	Nevill					HOME P.A		LAND				
-	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea one cause on each line.	th. Do not en	ter the mode of	dying, such as	cardiac or re	spiratory arrest,		In	pproximate nterval Between			
icían dical	Immediate Cause (Finel									nsat and Death			
iner	disease or condition resulting in death)	a Cardiomyopa	thy							years			
- A		Due to (or as a consequence of):											
nin nin		b Hypertensio	n						years				
bunel-transit													
for use es the bunel-transit clan/Medical Examir	that initiated events resulting in death) Last	Dua to (	or as a consec	quance of):	1								
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etached for us Physician	Part tt. Other significant conditions co			- 11/10			10			he cause of deat			
be detached for by Physic	Chronic obstructi	ve pulmonary	diseas	e, alcol	nolism		1/X Yes	2□ No	3 Proba	bly 4□Unkno			
2 should pleted							24a. Was en ei performed	utopsy I?	availe	autopsy findings able prior to pletion of cause ath?			
rector, page							1 ☐ Yes	2 No	10	Yes 2□ No			
Be C	25. Was case referred to medical				26. Place	of Death (C	heck only one)						
= 0	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA	Other:		5 Residence	e 6 □Othe	er (Specify)	12 Span			
- T	27. Manner of Death	28a. Date of Injury	28b. Time o		njury at Work?		Describe how i						
completely filled in by the funeral Medical Certification:	1. Natural 5 Pending 2 Accident investigation 3 Suicida 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At building, etc. (Spec	nome, farm, st	M	Yes 2		Location (Stree City or Town, S		er or Rural F	Routa Numbar,			
edical Cel		raician: To the best of my kn iner: On the basis of examin and manner stated.											
E 2	29b. Signature and title of certifiar	and mainer stated.		29c, Lic	ense number		29d.	Date signed	(Month, Da	av. Year)			
3		tenv			50 178	65		pril	0	.000			
Ms	30. Name and address of person who of Dr. Bollino, 922  31. Date filed (Month, Day, Year)		way, L		1D 215	02							

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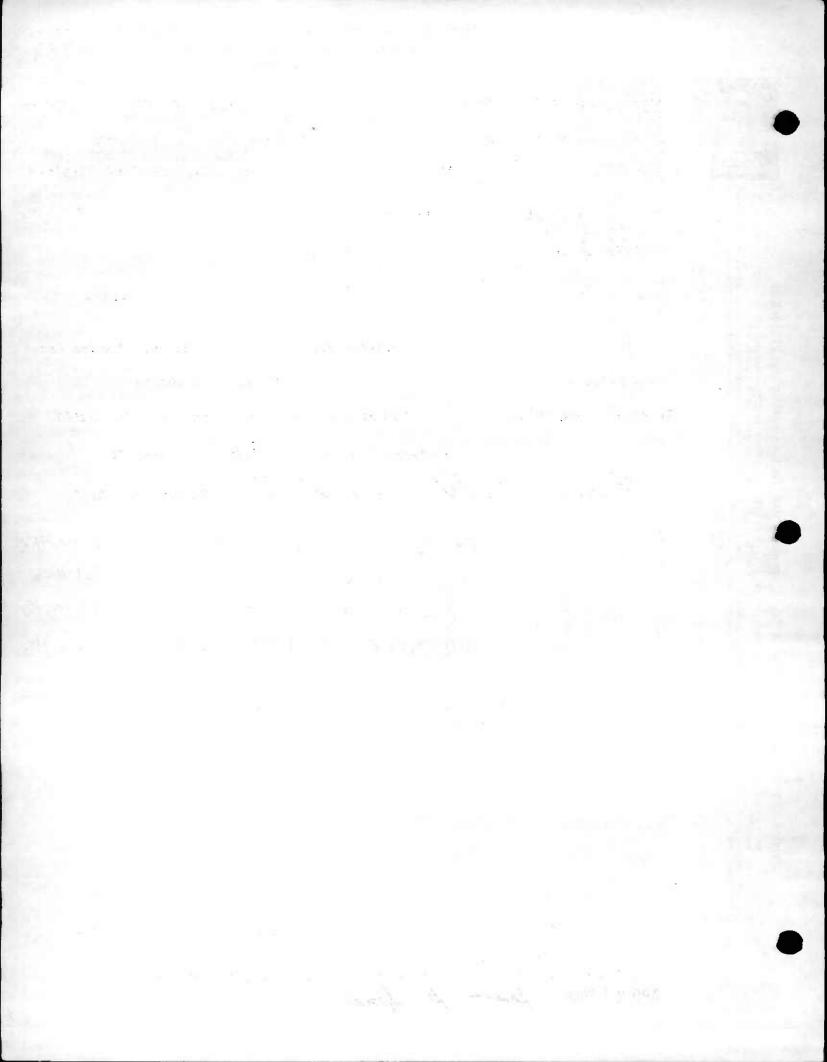
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** YVONNE LOUISE ROGERS 2000 April 17 5:30 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Westernport Allegany If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**X**F Days Yrs. 233-58-3322 Director West Virginia Feb. 24,1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depentment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, it is Medical Evaninal must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Mineral Keyser 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 497 Ridge Street 26726 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 11. Marital Stalus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Private Sitter Elderly Persons Care 17 Falher's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Ritchie Cathiline Newhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Frankie J. Rogers/Son 260 Wright's Run Lane White Post, VA 22663 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) April 20 2000 Newhouse Cemetery Rig, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner ner ettanding physician and I for use as the bunal-transit Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Chronie Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequence of): ata has been signed by the e paga 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No this certificata Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1🛣 Certifying Physiclen: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 30. Name and address of person who contpleted cause of death (Item 23a) (Type, Print) RUS

State Registrar

390 Carskadon Lane Mahesh B. Shroff, M.D. 32. Registrar's Signature

Keyser, WV 26726



State of Maryland / Department of Health and Mental Hygiene 14765 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Physician Katherine Stein 07:29AM 19, April 2000 /Medical 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth Jul 12, 1915 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Min. Hours 214-07-4775 1 ☐ M 200 F 84 Yrs Director Usuel Residenca of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Weddell Examiner must be notified at 1 ☐ Yes 🏌 ☐ No Allegany Director MD Cumberland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 14405 Rephann Lane 21502 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Datas: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) Raca - American Indien, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hygiene. I important: If Hem 21 is marked other than "natural", or iten any injury or other traumatic avant 1 Nevar Marriad 2 Married Saltimore, Maryland 21215-0020 1□ Yes 25 No Specify: Specify: white ģ 9 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) homemaker own home 18. Mothar's Name (First, Middle, Maiden Surnema) 17. Father's Neme (First, Middle, Last) William Rephann Ella C (Dunn) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
12802 McKay Avenue; Cresaptown MD 21502 J9a Informant's Neme/Reletionship (Type, Print) John Loewendick nephew 20a Wethod of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Date 20c. Location - City or Town, State Burial 2 Cramation 3 Ramoval from Steta 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/21/ Cumberland, MD 21. Signetyne of Funeral Servica Licensee Schred Mes Fullyeral Home P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Cause (Finel diseese or condition rasulting in deeth) GASTROINTESTINAL BUEED ONE HOUR Examiner Due to (or es e consequence of) Examine ONE MONTH COAGULOPATH T attending physician and for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Lest Due to (or as e consequenca of): Box 68760 certificete be Physician/Medical Due to (or es e consequence of): ed by the a 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown been signed b CONFESTIVE HEART þ 24a. Wes en eutopsy parformed? 24b. Were autopsy findings available prior to Completed completion of causa of deeth? After this certificate has funerel director, page 2 2 2 No 1 Yes 2 No 1 Yes Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Neturel 5 Pending investigation deeth. 1 Yes 2 No 2 Accident Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) or A after 4 \( \text{Homicide} \) To the Hospital o within 24 hours af To the Funeral Di The Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifian 033417 (Md) APRIL 19, 2000 30. Nema and eddress of person who completed cause of death (Item 23a) (Type, Print) 1063 NATIONAL HIGHWAY - REAR LAVALE, MARYLAND 21502 JAMES R. MOEN, MO APR 2 0 2000 32. Registrer's Signature oaks

**DHMH 16 Rev 6/95** 

Registrar

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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State of Maryland / Department of Health and Mental Hygiene 0 14767

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	Division	1. Decedent's Name (First, Middle,	Last)							2. Date of De	eath Day	Year	3. Time o	l Death	
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	Examiner	4a Facility Name (If not institution,	give street end nun	nber)			- 1	4b. City, To	wn, or L	ocation of Deet		ty of Deeth			
		MORAN MANOR NURSING HOME WESTER									RNPORT ALLEGANY				
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr.												or Foreign	
	Director	217-12-1021 1 M 2 F 76 Yrs. Months Days Hours							Min.	8. Date of Bi (Month, Da MAR . 1	9,1924	MARY	lace (Stete stry) LAND	)	
	-	Usuel Residenca of Decedent													
	caty and	10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside C	City Limits	
	to Be a	WV MINER	RAL	KE	YSER								1 🗆 Yes	s 2X No	
	or 28a-f s be notified Director	10e. Street and Number				10f. Zip Code						10g. Citizen of Whet Country?			
	A ST	ROUTE 6, BOX	6414			2	672	6			U.S.A.				
	ther death with the Maryland r Items 23s or 28s-f show inner must be notified at Funeral Director	11. Marital Status		dent Ever in U,								ace - Americ	an Indian		
		1 Never Married 2 Married	Armed For	ces?	If Yes, specify Cuban, Mexican, Puent						В	ack, White,			
20	bours after burst, or its at Examina od by Fu	3 □ Widowed 4 □ Divorced	1 ☐ Yes If Yes, Give Year or Da	EX.	1 ☐ Yes 2 ₹ No Specify:						Spec	ity: WHI	TE		
Ş	hou hou	15. Decedent's		103.	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						16b. Kind of	Business/Ind	ductor		
21215-0020	ed within 72 ho ygiene. wer than "naturn it, the Medical.]	(Specify only highest	grede completed)		(Give	kind of wo	rk done	during mos	t of work	ing	TOD. KING OF	DUSINGSS/INC	Justry		
12	m Pan.	Elementary/Secondery (0-12)	College (1	-4or 5+)				,			FREDE	RICK	TAIL	ORIN	
7		17. Father's Name (First, Middle, La	per)		PK	ESSE	R	19 Moths	or's Nam						
Ĕ	m sees										(First, Middle, Maiden Surneme) PALMER Route Number, City or Town, Stete, Zip Code) SER, WV 26726				
菪	Men Men Men To To	CHARLES TITLO													
Maryland	2 sh and is m	19a. Informent's Name/Relationship										n, Stete, Zip	Code)		
	and n 27 wer fr	EDWARD R. SMITH	/ HUSBAI					6414	, KE	YSER, W	IV 2672	J 26726			
Baltimore,	T test	20a. Method of Disposition		CC	lace of Dispo	sition (Name to record or control	ne of ther plea	ce)	1	Dete	20c. Location	- City or To	wn, State		
Ĕ	Pages nat: If its rry or o	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			RT ASH				4	/25/00	FORT A	SHBY,	WV		
票	ppartiti poerta ny Inju	21. Signature of Funeral Service Lie	ensee		22	. Name er	d Addre	ss of Fecili	ty						
ä	80 F 8 8	1. 1/m. 1. (1)	4 1		U	PCHUR	CH E	UNER	AL H	OME, IN	C.				
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	Medical Examiner ial-transit Examiner Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	e		r es e conseq	uence of):	h	mg	C	arcin	out		2 m	nths	
68760,	icate be physicial is the bur edical	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c		as e consequ							1			
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m .	death d for u	Part II. Other significant conditions	contributing to de	ath but not resu	itting in the ur	nderlying c	ause div	en in Pert I	l.	23b. Dld	tobacco use d	ontribute to	the cause	of death?	
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æ	he law e has age 2									10	Yes 2 □No		Yes 2	] No	
Ø		25. Was case referred to medical						00 Di	I D		200		7103 20	7140	
5	ysicien: The i s certificate ha director, page To Be Com	examiner?	Hospitel:	10.000			Oth	ac:		th (Check only					
o	2 2 2 -	1 ☐ Yes 8 ☐ No 27. Manner of Deeth	1 ∐ Ir	patient 2 1	ER/Outpatien 28b. Time of		//	4 LONG	ursing He	ome 5 Res	how injury occi		y)		
5	ding Ph h. After th funeral	Natural 5 Pending	(Month	n, Dey Year)	Injury	м	8c. Injur Wor		No	200. 0 000100	now injury occ	21100			
Division	tal or Attending P is efter death. In Director: After the ed in by the funera Certification:	2 Accident investigat 3 Suicide 6 Could no	he					Yes 2□	140	and Laureign	(Canada and Alice	aba a a Dual	I Day to Mar		
≥	tar character of the ch	4 ☐ Homicide determine	206. FIECE	of Injury - At ho g, etc. (Specify		et, factory	, office				(Street end Nun wn, Stete)	nber or Hure	Houle Nur	nber,	
0	To the Hospital or Attending within 24 hours eltar deeth. To the Funeral Director: After completely filled in by the fune Medical Certification	(Check only 2' Medical Ex	Physician: To the I	sis of examineti	vledge, death	occurred	et the tin	ne, date en pinion, dea	nd place, oth occur	end due to the	cause(s) end r	nanner es st	teted.	(s)	
	thin 2 the mple	20h Signature and title of cartifier	and mann	er Stated.		20-	Linon	e number			29d. Date sign	and (Manth	Day Vosel		
	5 ½ ¢ 8	29b. Signature end title of certifier				290	. LIUSTIS	e number					oy, rear)		
	9		) )				SO	124	ey	(S.D.	4/25	12000			
	(44)	30. Neme and address of person wh	o completed cause	of deeth (Item	23a) (Type, I	Print)									
	Mus	Jesus Tan. M.D	- Frost	bura Pl	aza. F	rost	oura	, MD	215	32					
	State	Jesus Tan, M.D	0 35 Be	gistrar'a Signat	ure	Spar	K	,							

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** George N.M.N. Speir APRIL 26 2000 8:47 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Allegany Cumberland Sacred Heart Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Days Months 1 M 2 F Yrs 217-10-5832 Director Maryland 31-Oct-18 Usual Residence of Decedan 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2X No Directo Allegany r than "natural", or items 23a or 28a-f the Medical Examiner must be notific Maryland Frostburg 10e. Street and Number 12420 Carlos Road, S.W. 10f. Zip Code 10g. Citizan of What Country? 21532-U.S.A. 14. Race - Amarican Indian, 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, etc. Amed Policasi 1 M Yas 2 No If Yes, Giva Yaar or Detas: WWII filed within 72 hours after 1 Navar Married 2 ☐ Married 1 ☐ Yes 2 1 No 3altimore, Maryland 21215-0020 Specify. 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 9 route salesman 0 brewery permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if them 27 is marked other any injury or other traum. 17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) Be 2 Hugh Spelr, Sr. **Bella Stevenson** 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Isabella Skidmore Midlothian Maryland 21543-P.O. Box 593 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Frostburg Memorial Park 29-Apr-00 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Park. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical enov Examiner Examiner +CISION 000 attending physician and I for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Dissess or Injury that Initiated avents Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) rasulting in death) Last signed by the aid be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to complation of causa of daath? Completed 24a. Was an autopsy peed 2 NINO 1 ☐ Yas 1 ☐ Yas 2 ☐ No certificata Division of Vitai 80 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 Yas 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Invastigation 1 Natural Injury or Attendinaftar death. 1 Yes 2 🗆 No 2 Accidant 6 Could not be 3 Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, sfreet, factory, office building, etc. (Specify) filled in by 4 Homicida 24 hours a Funeral D 29a. Cartifier (Check only one) 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date end place, end dua to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune complately fi Medical 2 | Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and manner stated. 29b. Signature and titla of certifiar 29c. License number 29d. Data signad (Month, Day, Year) 2 APRIL 2 6 2000 30. Nama and addrass of person who susa of daath (Itam 23a) (Type, Print) Sivan herland MD 21502 Villai 915 Seton 31. Data filed (Month, Day, Year) 32. Registrar's Signatura APR 2 8 2000 Registrar

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31-Oct-18 Maryland

Maryland Allegany Frostburg

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P.C. Box 599 Midlothian Maryland 21543-Isobella Skidmore

Frostburg Memorial Fac. 29-Apr-00 Frostburg, Maryland

Durst Euneral Home, 57 Frost Ave., Frostburg, MD 21532

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** ELIZABETH 2000 SHORT APRIL 2323 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT & QUEEN ANNES HOSPITAL CHESTERTOWN If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 2, 1931 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Devs 1□ M 2₽F Months 68 217-28-3716 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Kent Chestertown 23s or 28s-t 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Box 235 Fay Road United States 21620 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 0 3altimore, Maryland 21215-0020 1 ☐ Yes 21 ☑ No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail - Dept. Store Sales Person pelli permit. Pages 1 and 2 should be file Department of Health and Mertal Hy, Important: If Item 27 is marked other any injury or other traumatic event, 00.00 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Josephine Hilton Howard Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 E. Avondale Road, West Grove, Pennsylvania 19390 Susie Miller – sister 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Deta 1 X Buriaf 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Specify) Camdem Cemetery - April 21, 2000 Canden, Delaware Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 Cypress Street, Millington, Maryland 21651 Approximate ause on each line. Approximate Will raff King, Approximete Intervel Batween Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 12 Arg Examiner Physician/Medical Examiner attending physician and for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 □ Probably 4 □ Unknown þ 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Be Completed 1□ Yes 2□No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physiolen: "within 24 hours efter death. To the Funeral Director: After this certifics completely filled in by the funeral director; p 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1[P Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mennar as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

State Registrar

APR 19 2000 **DHMH 16 Rev 6/95** 

29b. Signature and title of certifier

GEORGE

31. Date filed (Month, Day, Year)

30. Name and eddress of person who complete

e of death (ftem £39) (Type, Print)

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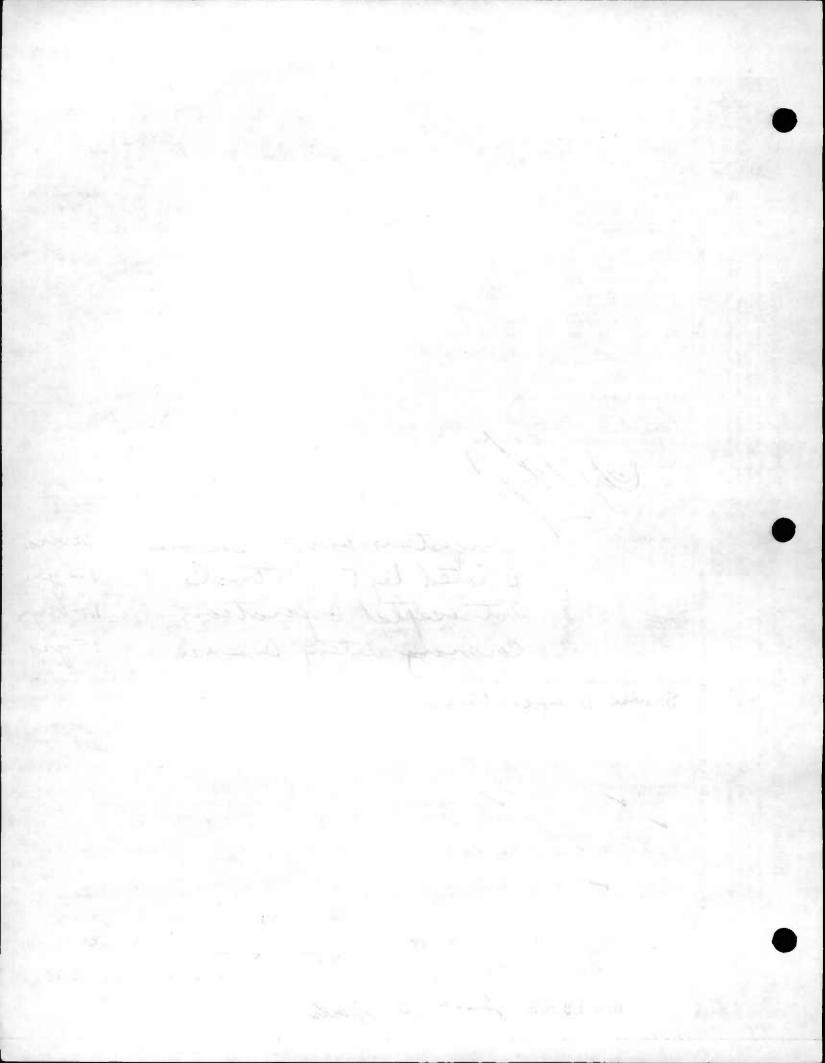
32. Registrar's Signature

29c. License number MD

D31974 100 BROWN

CHESTERTOWN

29d. Date signed (Month, Dey, Year)



					State of M	aryland		eparime C <i>ertifica</i>		Health and I Death	Mental Hy	rgiene U	U	14/10		
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Maryland 21215-0020	in 72 ho in matur Medical		15. Dece (Specify only his	dent's Ed thest gre	ducation de com <i>pleted)</i>		16e. D	ecedent's U	suel Occup work done	petion during most of world)	rking	16b. Kind of B	usiness/In	dustry		
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Baltimore,	Pagas 1 and nant of Haalt nt: If Item 2		20e. Method of Disposition 1 Burial 2 □ Cremati			20b. Pl	ece of D	isposition (f	Vame of		Dete			own, Stete		
			4 □ Donetion 5 □ Other (Specify) NCCOL Cemetery									Still Porking	Pond	, MD		
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	To the Hospital or Attending Physician: which 24 hours after death and the Funeral Director. After this cartific complately filled in by the funeral director,	edicai C	29a. Certifier (Check anily anel) 2 Medical	ying Phy ai Exam	yeician: To the best of the be	examineti	riedge, d	leeth occurre or Investigeti	ed et the ti	me, dete end plece oplnion, deeth occu	e, end due to the arred et the time,	cause(s) end me dete end place,	enner es s end due t	iteted. o the cause(s)		
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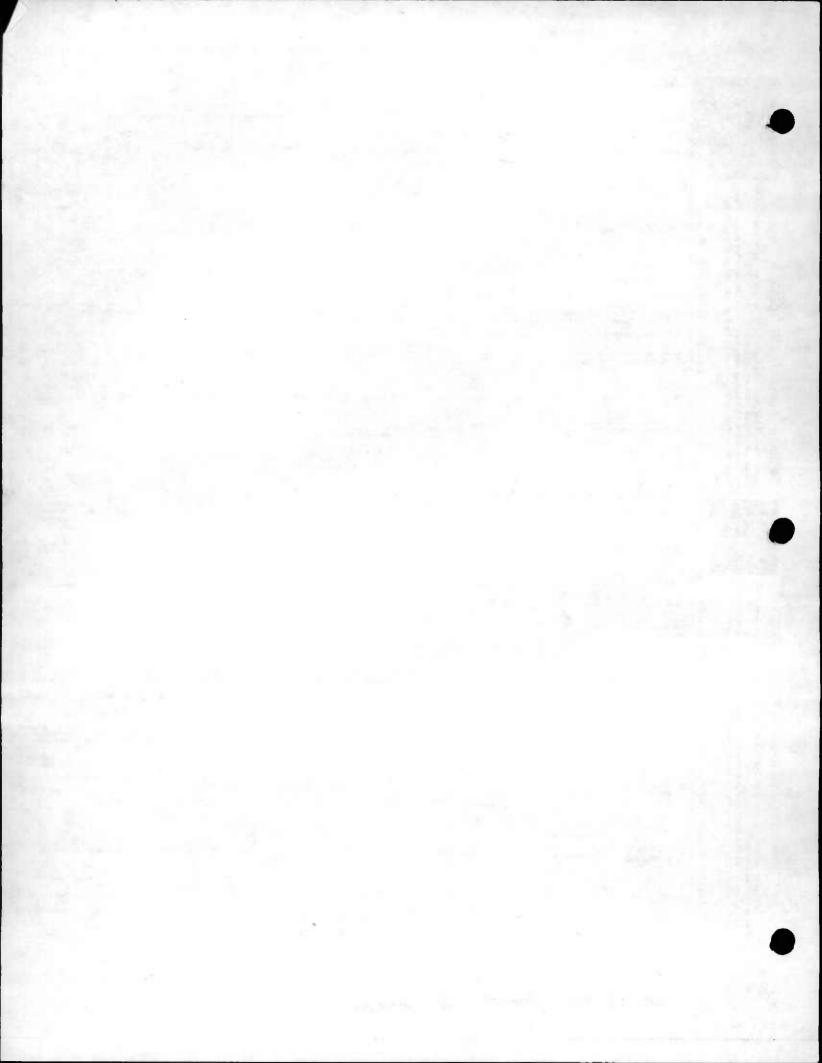
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amended #6, 4/13/00, J.J., Kent Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** James Herbert Stokes 8 2000 April 2000 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Kent and Queen Anne's Hospital, Inc. Chestertown Kent 7. Age (In yrs. last birthday) If Under t Year If Under 24 Hrs. 8. Date of Birth Pay, Year, 1914 (Stete or F County) May 17, 1914 (Chestertown, 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** M-210 Months Days Hours Yrs. 216-09-6021 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ust be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11639 Lynch Road 21678 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1XXVes 2 □ No if Yes, Give Yeer or Detes: WWII Hemm Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or from any Infury or other treumatic event, the Modical Experience. 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Auto Mechanic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Herbert Stokes Lottie Jane Foreman 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Rebecca Kendall Stokes/Wife 11639 Lynch Road, Worton, Maryland 21678 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/11/2000 Chestertown, MD Chester Cemetery 21. Signature of Funeral Service License 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approxime Approximete tntervel Between Onset end Death **Physician** /Medical Immediata Ceuse (Final Hemorrhagia Covebro Vascalar Accident day diseese or condition resulting in deeth) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? HTN Inadequatly Controled Durypet Inadequally Controled 1 Yes 2 No 3 Probably 4 Unknown Records. Medical Certification: To Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? \*Chol-DotTreated per pto Choide/ Cevebro Micro Vascular 24a. Wes an eutopsy Disease / Old CVA by CT. 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital P Hospital or Attending Physician: 24 hours after death.

Puneral Director: After this certified letely filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: JU Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 1 X Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier within 2 To the To the 29b. Signeture and title of mertiling 29c. License number 29d. Date signed (Month, Day, Year) 1) 0050996 2000 Downson 30. Name end address of parson who completed cause of death (Item 23a) (Type, Print) 10+1Neil Stoddard, 100 Brown Street, Chestertown, Maryland 21620 31. Dete filed (Month, Day, Year)
APR 1 1 2000 32. Registrer's Signature Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 26 per phys. G783 5/8/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Year Stahler 0400 Ralph 2000 Apri 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Parkton Miller Road Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 10, 1948 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Deys 1**X** M 2□ F Months Hours 52 Yrs Pennsylvania 218-52-4071 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No Baltimore Cockevsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 322 M Limestone Valley Dr. 21030 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify. 3 ☐ Widowed 4 X Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Small Appliance Elementary/Secondary (0-12) College (1-4or 5+) 1 Engineer Manufacturing 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph W. Stahler Doris E. Palmer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Murray Stahler/Son P.O. Box 891, Sparks, MD 21152 20b. Plece of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Inc. April 25 Yorktowne Caskets, Cremation Service 1 ☐ Burial 2 XCremation 3 ☐ Removel from State York, PA 17404 4 ☐ Donation 5 ☐ Other (Specify) 2000 22. Name end Address of Facility nature of Funeral Service Licensee J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 sed the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, Approximate Intervel Between Onset end Deeth 23a Part Enter the disease, or companies on heert failure. List only Immediate Cause (Final disease or condition resulting In death) irrhosis Zuears Due to (or es e consequence of) Intection tepatitis Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): 2 weeks Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one)

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To the Funeral Director: All complataly filled in by tha fu

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P.O. Box 68760.

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Martlat Hygiana. Important: If term 27 is marked other than "natural; or items 23a or 28af show any injury or other traumatic event, its Marical Examinat ment to nother traumatic event, its Marical Examinat ment to nother traumatic event, its Marical Examinat ment to nother traumatic event, its Marical Examinat

Baltimore, Maryland 21215-0020

Examiner usa as the burial-tragsit signed by the attending to be detached for use as P funeral Certification:

Physician/Medical p Completed Be

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical exeminer? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Deeth 5 Pending investigation 1 Netural 2 Accident 3 ☐ Suicide

6 Could not be determined

Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 4 Residence 6 MOther (Specify) house s 28d. Describe how Injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated. 29b. Signeture and title of certifier

Cawkins Flock, MD

29c. License number

29d. Date signed (Month, Dey, Year) April 24,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Melissa Hawkins-Holt

N. Greene St

Baltimore, MD 21201

State Registrar

Medical

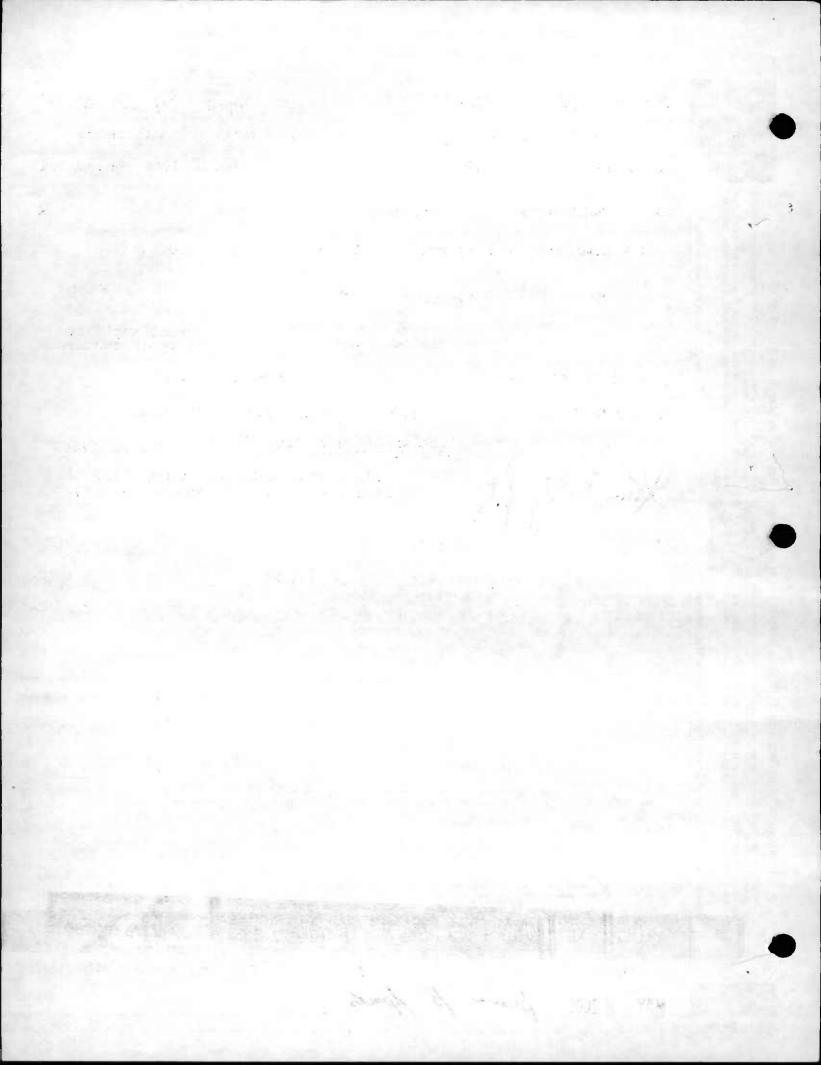
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4 Homicide

29a. Certifier

32. Registrer's Signature

**DHMH 16 Rev 6/95** 



State Registrar

**DHMH 16 Rev 6/95** 

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V. RAMULU \*31. Data filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

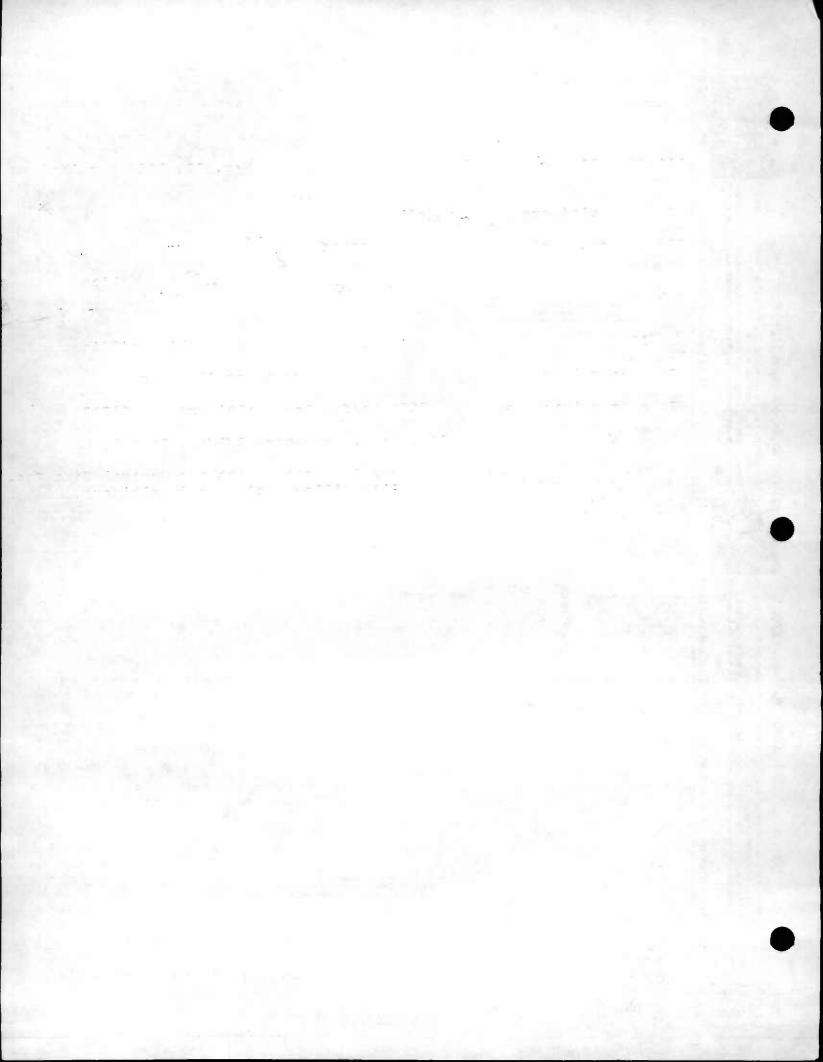
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AVENUE, BALTIMORE, MO

APRIL 28,2000



BALTIMORE, MARYLAND 21215-0020

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HOSPITAL DR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed withings hours after death. Page 6 may be retained by the hospital	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached i within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
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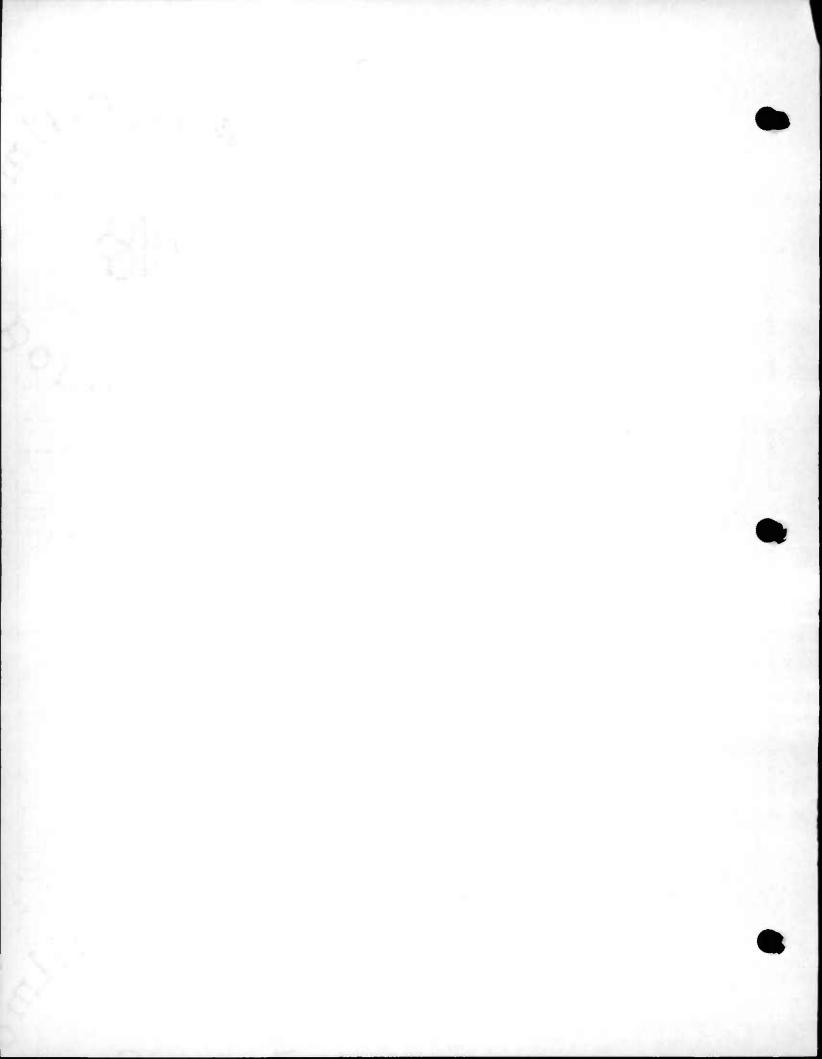
Amended Item 30 per Field Rep., 4/20/2000, Carroll Co., wil jab

14774 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RALPH SCHUCHAR 1230 2000 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign July 26,1921 1 9 M 2 | F PA 212-32-4264 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH 1305 Humbert Schoolhouse Rd. Carroll Westminster 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Carrol1 Westminster 1 YES 2 1 NO 10e. STREET AND NUMBER 101. ZIP CODE 21158 10g. CITIZEN OF WHAT COUNTRY? 1305 Humbert Schoolhouse Rd. USA 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify: 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes intery/Secondary (0-12) College (1-4 or 5+) 10 Farmer Agriculture 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Emma Staub Nicholas Schuchart 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) -Wife Pauline M.Schuchart 1305 Humbert Schoolhouse Rd. Westminster, MD21158 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 4 Donation 5 Dother (Specify) 4/21/2000 Silver Run, MD Mary's Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 17340 Little's F.H. 34 Maple Ave.Littlestown, PA 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onaet and Death disease or condition\_\_\_ CARONARY ARTERY YEARS reaulting in death) QUE TO (OR AS A CONSEQUENCE OF) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS VALVE REPLACEMENT AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES TO NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 - YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 52 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, offics building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide

2 \_\_ MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. 296. SIGNATIURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) MO ZZZZ39E 2000 34 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 423. Washington St. ALLOZ GETT BURG

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.

2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** SEARS EDWIN LOUIS 2000 0445 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 24 Hrs. Hours Min. If Under 1 Year 6. Sex 12 M 2 ☐ F Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Hours Months Yrs. Director 217-05-9370 1921 JAN 10 Maryland Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Herne 23s or 25s-f show 1 Yes 2 No Taylors Island MD Dorchester Director the Medical Examiner must be notifi-10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21669 4529 Hooper Neck Rd. Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Wes Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 10 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white by 3 Widowed 4 Divorced Yaar or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) commercial waterman seafood unk. 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Violet Kiefer Sara Charles Edwin Sears 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) . Post Office Box 82, Taylors Island MD 21669 Gertrude H. Sears - wife Department of Health Important: If Item 27 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4-22-2000 Taylors Island Md. 4 ☐ Donation 5 ☐ Other (Specify) Brick Churchyard 22. Nama end Addrass of Facility 21. Signature of Funeral Service Licenses Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Arterioscleratic Heart Disease Examiner Due to (or as a consequence of): Physician/Medical Examiner Sepsis 7 days sician and bunal-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated evants rasulting in death) Last Due to (or as e consequence of): Box 68760, ettending physician for use es the buria Due to (or as e consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Malnutrina Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy partormed? Completed 1 Yes 2 No 1 ☐ Yes 2 PNo To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate completely filled in by the funeral director, pag or Attending Physician: after death. 25. Wes case referred to medical axaminar? Be 26. Piece of Death (Check only one) Hospitel: 1 ⊅npatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyelotan: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) authur MM 4-20-2000 47924 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) NOMAN THANKY AURORA STREET 300 CAMBRIDGE 31. Deta filed (Month Pay, Year) 2000 32. Registrer's Signature State Registrar

AFR 2 1 2000 James S. Agrass

# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14776 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Month Year **Physician** JANICE CATHERINE TAROSKI April 13, 2000 21:15 /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY Months Deys Hours Min. 8. Date of Birth (Month, Dey, Year)

AUG. 9,1935 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign
Country) **Funeral** 1□ M 2♀ F Yrs. (UNKNOWN) 159-30-7929 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinar must be notified at 1√2 Yes 2 □ No MD ALLEGANY CUMBERLAND Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 818 SHRIVER AVENUE 21502 U.S.A. death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Menter Exempted. 1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Detes: 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 **OPERATOR** RESTAURANT 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be (UNKNOWN) ANNA SCRIP 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DESIREE DIGGS / DAUGHTER 818 SHRIVER AVENUE, CUMBERLAND, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY 4/14/00 CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es aconsequence of): Examiner physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Box 68760. Physician/Medicai sehen 980 ò 23b. Did tobacco usa contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. detached 3 Probably 4 Unknown 1 Yes No Division of Vital Records, þ 2 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed peeu page 2 certificate has 1 Tes 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident t) 0 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner steted. 29a. Certifier edicai 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie April /4,2000 wa 30. Name and address of person who use of death (Item 23a) (Type, Print) Setun Med 902 umberland, mD 21502 Mehanno John 31. Dete filed (A) 32. Pegistrer's Signeture State

Registrar

answer all the first

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State of Maryland / Department of Health and Mental Hygiene 00 11,777

			(	Certificat	e of	Death		Reg. No.	U	
Division	1. Decedent's Name (First, Middle, L	ast)		Marin In			2. Dete of Dee	eth Day	Year	3. Time of Deeth
Physician /Medical	ANNA CATHERINE	TURNER					APRIL	25 200		8:20 PM
Examiner	4e Fecility Neme (If not institution, g	ive street and number	)			4b. City, Town, or	Location of Deeth	4c. County	of Death	
	CUMBERLAND NURSI	NG HOME				CUMBERLA		,	EGANY	
eral ctor	217-10-4177	Sex 1 M 2 X	ge (In yrs. last birth	Months	1 Year Deys	If Under 24 Hrs Hours Min	. (Month, De	y, Yeer) 2 1914	9. Birthp Cour MAR	plece (Stete or Foreign http) YLAND
-unerai Director	Usual Residence of Decedent  10e. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
to	MARYLAND ALLEG	ANY	CUM	BERLAND						1 ☐ Yes 2 No
Director	10e. Street end Number			10f. Zip	Code			10g. Citizen of \	Whet Cour	ntry?
ai	13616 MOORES HOL	LOW ROAD S	S.E.	21	502			U.S	S.A.	
by Funeral	11. Merital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Wes Deceden Armed Forces 1  Yes 2  If Yes, Give Yeer or Detes	? I No	13. Was Dece If Yes, spe 1 ☐ Yes	cify Cub	dispanto Orlgin? (S en, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	ck, White,	
Completed	15. Decedent's I		16e. E	ecedent's Usu	al Occup	pation during most of wo	rking	16b. Kind of B	usiness/In	dustry
pie	(Specify only highest g Elementery/Secondary (0-12)	College (1-4or		ife. DO NOT u	se retire	d)	"hilly			
50	8			ES ASS	ISTA	NT		NURS	ING	
Be	17. Fether's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middle,	Maiden Suman	ne)	
10	EPHRIAM STAFFO	RD				MINNIE	BELLE R	ICE		
_	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street	t end Number or A	urel Route Numbe	er, City or Town,	State, Zip	Code)
	ROBERT E. TURNER		SON 137	09 MOO	RES	HOLLOW R	OAD S.E.	CUMBER	LAND	MARYLAND
	20e. Method of Disposition		20b. Pleca of I	Disposition (Na	ne of		Dete	20c. Location -	City or To	own, State
	1 ☐ Burial 2 ☐ Cremation 3		9	ON CEME			28 2000	CIMBERT /	A NITO M	ARYLAND
	4 Donetion 5 Other (Spec	1996	III IILIGI			ess of Fecility	2000	CHDEKLE	AND FI	ARTIAND
	Dale of	Mount		MERRIT	T-A!	DAMS FUNI				
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each	ed the death. Do no	t enter the mod	CAT le of dyi	ng, such es cardia	c or respiratory er	JAND MAI	RYLAN	Interval Between
i										Onset end Deeth
	Immediate Ceuse (Finel disease or condition	e CA	Rewom	A C	02	S			1	one year
	resulting in death)		Due to (or es e co							0
ine	10113111-72	h h							1	
Examiner	Sequentially list conditions, if eny, leading to immediate		Due to (or es e co	nsequence of):						
	cause. Enter Underlying Ceuse (Disease or injury									
edicai	that initiated events resulting In deeth) Lest	C	Due to (or es e co	nsequence of):				-	1	
Med	and the second second								1	
No.		d							1	
Sicia	Pert II. Other eignificent conditions	contributing to death	but not resulting in t	he underlying o	ause qi	ven in Pert I.	23b. Dld 1	tobecco use co	ntribute t	o the cause of death?
Physician							10	-	3 □ Pro	
by P	Corrothey	MRJ EN	1 015%	ASE				7		7.172
	CORUNTARY			0.4.	Λ.			en eutopsy		ere eutopsy findings
Completed	CONGE	STIVE 1	TEAR	MILL	ME		perfo	rmed?	CC	reileble prior to empletion of cause
mp										deeth?
							10	res 2 No	11	☐ Yes 2☐ No
20	25. Wes case referred to medical exeminer?						eth (Check only o	ne)		
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2□ ER/Outp		JA		Home 5 ☐ Resid	denca 6 □Oth	ier (Specia	(y)
	27. Manner of Death  Naturel 5 ☐ Pending 2 ☐ Accident investigati	28e. Dete of In (Month, D	jury a <i>y Year)</i> 28b. Tii Inj	me of tury M	28c. Inju Wo	ryet rk? ]Yes 2 ☐ No	28d. Describe	now injury occur	red	
Certification:	3 Suicide 6 Could not determine	be 28e. Piece of Ir	njury · At home, farr	n, street, factor	y, office		28f. Location (City or Tox		per or Rum	el Route Number,
edicai		hysician: To the besiminer: On the basis and menners	of examinetion end/							
Me	29b. Signature end title of certifier			29	c. Licen:	se number		29d. Date signe	ed (Month,	Dey, Year)
5	) Asia	elm			D 2	6907		APRIL	27	2000
3	30. Name end eddress of person who		deeth (Item 23e) (T			,				
3	DR HARJIT SIDHU				IMRI	FRT AND MA	ARAI VIID (	21502		
	DICTIONAL STORY	וכדת ראנ	TOT WALLSI	MUMI!	[ער די	SKJAND PI	TILL TIME A	-1302		

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Registrar

APR 2 8 2000

APR 2 8 2000 James to species

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Dey Month Yeer **Physician** Lucille True 27, 2000 April 4:35 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Allegany Memorial Hospital Cumberland 8. Date of Birth (Month, Pey, Year) Feb 4, 1930 If Linder 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) Deys Months 215-26-7042 70 Yrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No Allegany Cumberland 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number 544 Patterson Avenue 21502 USA Funeral Wes Decedent Ever in U.S. Armed Forces? 1 Yes No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: white þ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Child Day Care Provider Day Care 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) (O'Donnell) Robert Corbin 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Deborah True Easton P.O. Box 1813; Cumberland MD 21502 daughter 20b. Plece of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other place) X Buriei 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Hillcrest Memorial Par4/29/ Cumberland, MD 21. Signature of Funeral Service Licensee Scarpeding Fullyeral Home P.A. Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only enactause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final ANOXIC ENCEPHALOPATHY 3 MOS diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequenca of): Physician/Medicai Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work?

Box 68760 certificete be P.O. Records. Division of Vital

**Funeral** 

Director

tem 27 is marked other than "natural", or frems 23s or 25s-f show other treumstic event, the Medical Examinal must be notified at

Hygiena.

**Physician** /Medical

Examiner

attending physicien end for usa es the burial-transit

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

After this certificate has Certification: i or Attending Patter death. after death. Director: Aft d in by the fur To the Hospital or Atte within 24 hours after de To the Funeret Directo completely filled in by the

Medicai 3

State Registrar 29b. Signature and title of certifie stevera

5 Pending investigation

6 Could not be determined

29c. License number

Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner es steted.

— Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

D-14865

1 ☐ Yes 2 ☐ No

2000

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Barrera, Memorial Hospital Medical Bldg., Cumberland, MD Dr. R.

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Dete filed (Month, Dey, Year)

1 Naturei

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

APR 2 8 2000

32. Registrer's Signeture

APR 28 20 James & Sparie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Date of Deeth 3. Tima of Deeth Day Month **Physician** M. TURNER THOMAS 2250 15 00 /Medical 4a. Fecility Nama (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Daath Examiner SNOW HILL NURSTING + REHAB CENTER 2000 HILL MO WORCESTER If Undar 24 Hrs. If Undar 1 Yaar Birthplace (State or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F 229-48-2921 62 Director 3/4/38 Usual Residence of Decedent deeth with the Meryland 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other then "natural; or flems 23a or 28a-f show traumatic event, the Moulcal Exactings must be incitted as MD TYTYAS 2□No Director Wicomico Parsonsburg 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 7146 Wainwright Avenue 21849 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? ★★Yas 2 □ No Wes Decedant of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, Whife, etc. pemilt. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health end Mantel Hygiene. Important: if Itam 27 is marked other than "netural", or fler mortant: if Itam 27 is marked other than "netural", or fler any injury or other traumatic event, the Mexical Examination once. 1 □ Never Merried 2 □ Merried 3altimore, Maryland 21215-0020 If Yes, Giva Yaar or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 N Divorced 1953 Completed 15. Decedent's Education (Specify only highest grada complated) 16e. Decedent's Usuel Occupetion (Give kind of work done duning most of working life. DO NOT use retired) 16b. KInd of Business/Industry Flamentery/Secondary (0-12) College (1-4or 5+) Real Estate Broker Housing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Walter Alvin Turner Edith Branche 19b. Meiling Address (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) 7146 Wainwright Avenue 19a. Informant's Name/Reletionship (Type, Print) Dorothy Turner Matsatsos Parsonsburg, MD 21849 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other placa) Data 20c. Location - City or Town, Stata 1 ☐ Buriel 2 ØCremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Othar (Specify) Cambridge Crematory 4-17 Cambridge, MD 22. Nama and Address of Fecility Short Funeral Home 21. Signature of Funeral Servica Licensee 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one cause of each line. Delmar, DE 19940 **Physician** Immediate Ceuse (Finel disease or condition resulting In daath) /Medical Examiner Examiner ettending physician and for use as the bunel-transit The law requires that the deeth certificets be executed Sequentially list conditions, if eny, leading to Immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequance of): Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) signed by the e Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of causa of deeth? Completed 24e. Wes en eutopsy certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes casa referred to medical Be 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Mannar of Death 28b. Time of 28d. Dascribe how Injury occurred 1 Neturel 5 ☐ Pending 1 □ Yas 2 □ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - Af home, farm, streef, factory, offica building, atc. (Specify) 4 | Homicida 1 Certifying Physician: To the basi of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

lozo th

32. Registrar's Signature

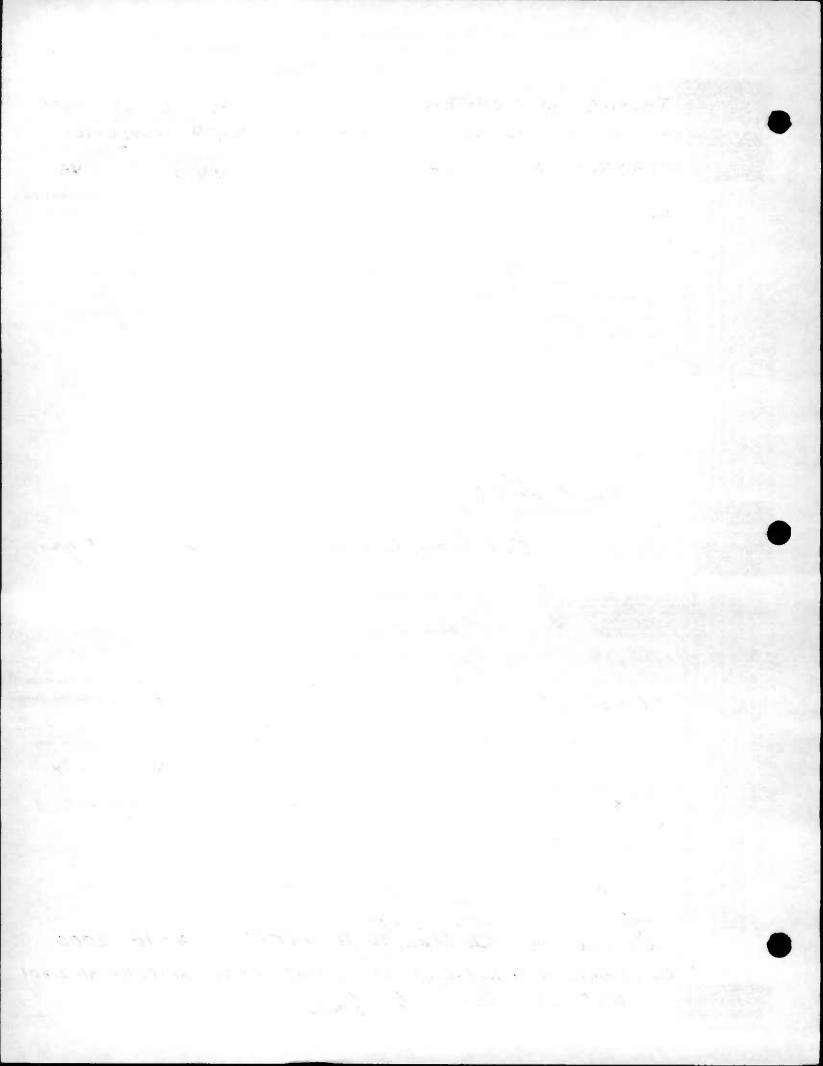
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GREGORIO M. BELLOSO, N.D., 5302 CHINABERRY DR., SAUSBURY, MO 21801

4-16-2000

State Registrar pour

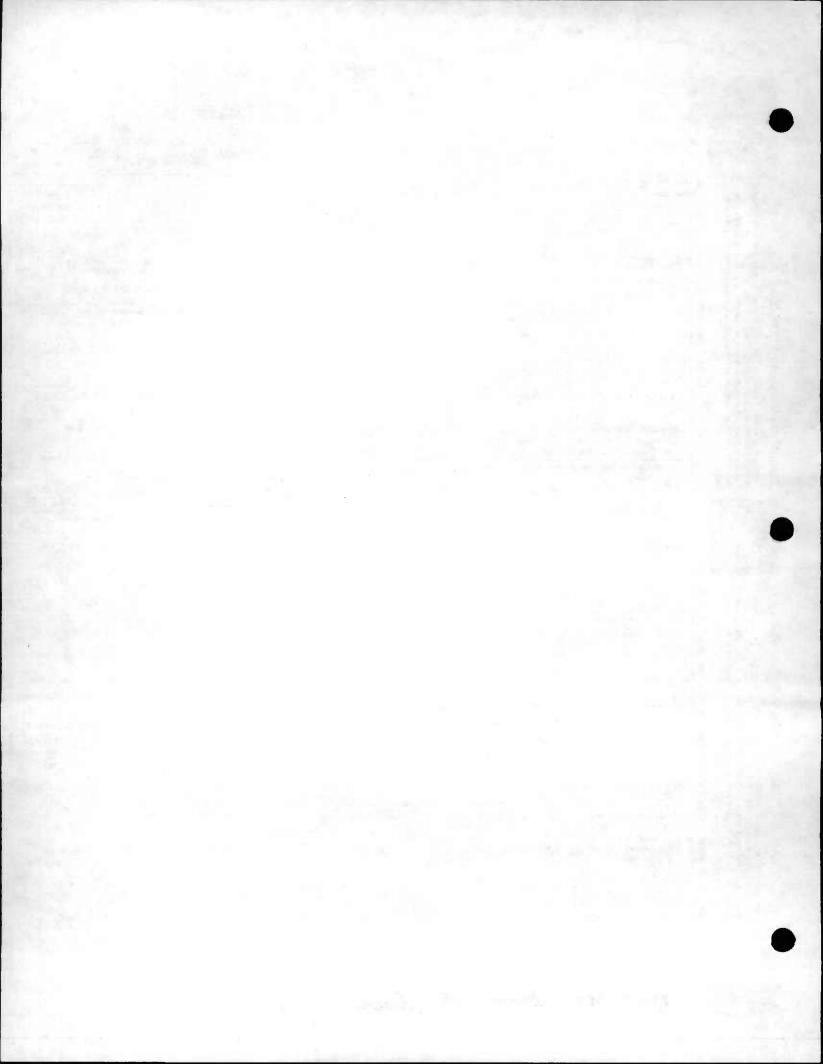
Name and address of person who complated causa of death (Item 23a) (Type, Print)



# Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14780 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** James Edward Thompson April 6 2000 1620 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Kent & Queen Anne's Hospital Chestertown Kent 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) October 27, 1926 Maryland 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 218-20-9552 73 Director Usual Residence of Decedent 10c. City. Town or Location Show 10d. Inside City Limits Maryland 1 ☐ Yes 2 € No Directo Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 315 John Powell Road 238 21668 USA 14. Race - American Indien, Black, White, etc. naturel', or itema 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. other than Elementery/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Indian Acres Camp Ground other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths eny linjury or other traumatic event pates. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilson Thompson Edith Libey 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Louise Thompson 315 John Powell Road, Sudlersville, MD 21668 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removet from State 4 Donetion 5 DOther (Specify) Church Hill Cemetery 4/10/2000 Church Hill, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23e. Pert1. Enter the dismain shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one cause on each line. Approximete tntervel Between Onset end Death **Physician** tmmediate Ceuse (Finel disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or es a consequence of): Physician/Medical Examiner ANSCESS DIVERTICULAR physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In death) Lest Due to (or es e consequence of) P.O. Box 68760. Due to (or es a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE SEVERE ADRIC INSUFFICIENCY Records, Be Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? CHRONIC OBSTRUCTIVE PLLMONARY DISEASE PERIPHERAL VASCULAR DISEASE 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturet 5 Pending death. To the Hospital or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fo 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier edical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ku & Noble up D0041587 00 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 8 Helen A. Noble, 122 Speer Road, suite 5, Chestertown, MD 21620 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State APR 11 2000 Registrar

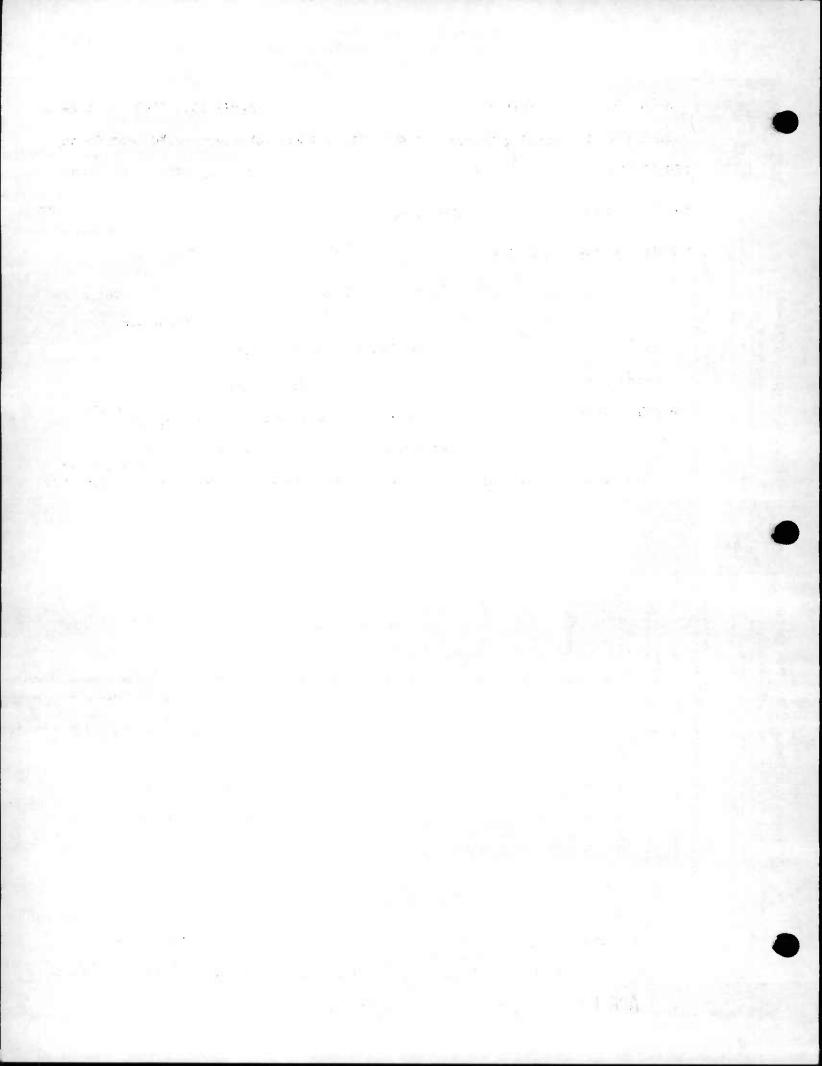


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State of Maryland / Department of Health and Mental Hygiene

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					C	ertificate c		ra montan riye	leg. No.	14/01
			1. Decedant's Nama (First, Middla, Last)					2. Data of Dea	th	3. Time of Death
	Physici /Medi		ANNA S. TAY	LOR				Month April 1		8 AM
	Examir		4a. Facility Nama (If not institution, giva street and	d number)			4b. City, Town	, or Location of Death	4c. County of	
				g Center	#	200 Morg	nec Rd.	Chestert	own Md K	ent County
	Funeral		5. Social Sacurity Number 6. Sax	7. Aga (In yrs.		Months Da	ar II Undar 24	Min. 8. Data of Birth	y, Year) 9	. Birthpleca (Stata or Foreign Country)
	Director		Usual Rasidance of Decedant	93	Yrs			Dec. 31		Maryland
	and and		10a. Stata 10b. County	10c. City	y, Town or	Location				10d. Inside City Limits
	-f sh	ō	Md. Kent	RFD	Wo	rton				1 ☐ Yas 2√☐XNo
	r 28a	Director	10e. Straat and Number			10f. Zip Cod	θ		10g. Citizen of Wha	at Country?
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	deet	Funeral	11. Marital Status 12. Was I	Dacadant Evar in U, d Forces?	S. 1	3. Was Decedant	of Hispanic Orlgin	n? (Specify Yas or No- Puarto Rican, atc.)	14. Raca -	Amarican Indian,
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7	filed within 72 hours efter deeth with the Maryland Hygiene. ther than "netural", or items 23a or 28e-f show ent, the Medical Examine Frunt be motified at	Completed	Elamantary/Secondary (0-12) Collag	ga (1-4or 5+)						
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au	id be entai	To Be	Harry Taylor				TDA	****		
ar <sub>Z</sub>	2 should be end Mental is marked or sumatic eve	-	19a. Intormant's Name/Ralationship (Type, Print)		19b. M	ailing Addrass (Str	eet and Number	WALKER or Rurel Routa Numbe	r, City or Town, Sta	ata, Zip Coda)
			Dorothy Joiner		# 2	5939 W	orton Lv	nch Rd 11-	No. 1	21678
ore	of He of He		20a. Mathod of Disposition 1 Ⅺ Burial 2 ☐ Cramation 3 ☐ Ramoval to		lece of Di	sposition (Name of	placa)	nch Rd. Wo	20c. Location - Cr	ty or Town, Stata
<u>Ĕ</u>	Pages nent of I ant: if ite ury or of		4 □ Donation 5 □ Othar (Specify)	Ur.	ion	Cemetery		4/18/00	Worton,	
Baltimore,	permit. Pages 1 end Depertment of Health Important: if Item 27 any Injury or other tr once.		21. Signature of Funaral Sarvica Licansae	۸۸		22. Nama and Ad	drass of Facility	1.6	211 He	ron Point
	205 20		* HWillis W	elle		WIIIIS W	errs Fur	eral Servi	ce Chest 21620	ertown, Md.
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	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting In daath)	Senil	e	Slem	entra			may year
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80 B	th ce tendii		d							
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	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	edical	29a. Certifier (Check only 2 ☐ Medical Examiner: On the	the best of my know	wledge, de	eth occurred at the	a tima, data and p	place, and due to the c	ause(s) end mann	er as stated.
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H	Registr	- 1	APR 1 7 2000	Seneva	B.	Spark	2			



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Unangst Constance April 22, 2000
postion of Death 4c. County of Deeth /Medical Hughes 5:30 AM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death **Examiner** 5626 Bar Neck Road Cambridge Dorchester 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Months 1□M 2⊠F Days Yrs Director 154-36-1491 Jan 2, 1903 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5626 Bar Neck Road 21613 US Funeral Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes YN No If Yes, Give Year or Dates: 1 Yes 2XXNo Specify: White Specify: by 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gilbert William Hughes Kate Brereton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hervey B. Unangst P.O. Box 1894 Kilmarnock, Virginia 22482 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/23/00 Salisbury, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Arteriosclerche Heart Dream /Medical Immediate Cause (Final disease or condition resulting in death) 1ears Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Malnutrition þ Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 15—Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA D 47924 4-22-2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE NOMAN THANWY STREET

State Registrar

APR 2 4 2000

300 AURORA 32. Registrar's Signature

28a-f show

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Items 23a

Demit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or its

Important: If item 27 any injury or other tr

physician and s the buriei-transit

sate hes been signed by the pege 2 should be detached

Hospital or Attanding Physician: '24 hours efter death. Funeral Director: After this certifica stely filled in by the funerel director; g

24 hours efter Funeral Dire letely filled in b

To the Hosp within 24 ho To the Fune completely f

The law requires that the death certificate be executed

Box 68760

P.0.

Records,

Division of Vital

Baltimore, Maryland 21215-0020

Examiner must be notified at

Marine San Marine Marine Committee C

Amended #28a, NLS, 4/21/00, Allegany Co.

#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

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eral	5. Social Security !	Number	6. Sex 1 <b>X</b> M 2 ☐ F		rs. last birthday)	If Undar 1 Yaar Months Days	If Undar 24		Day, Year)	9. Birthp	laca (State or Foreign
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Registrar

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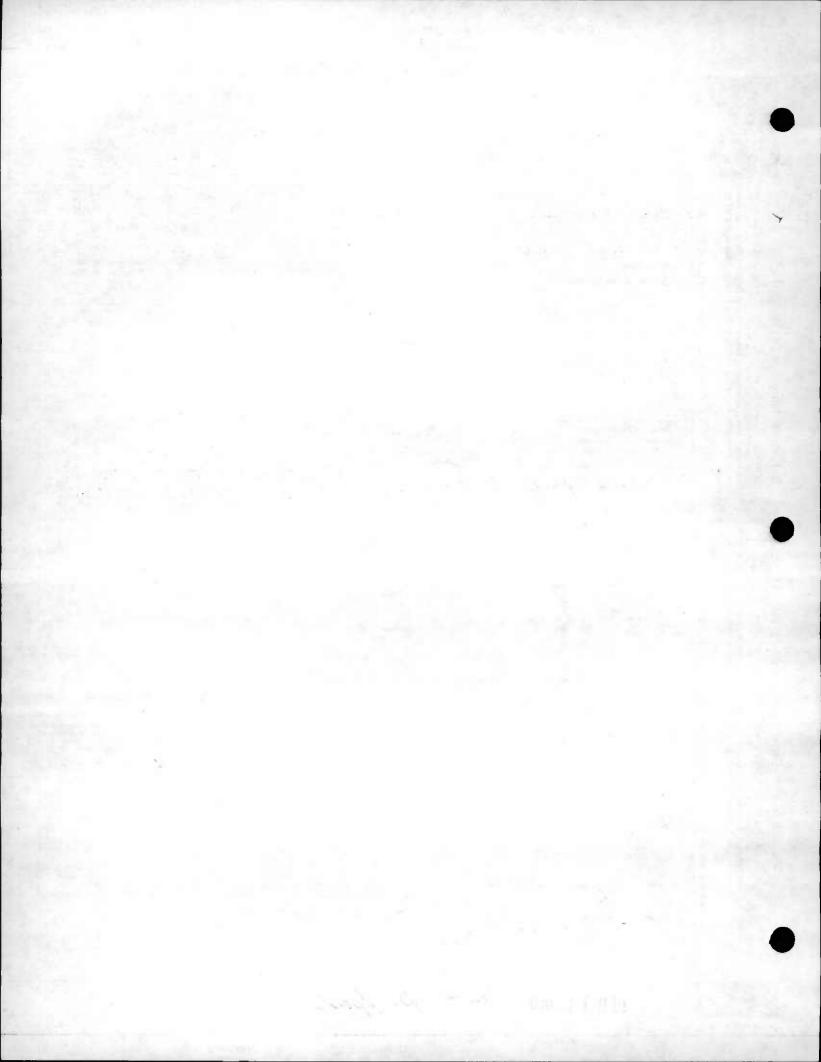
State of Maryland / Department of Health and Mental Hygiene 478 ls Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day 2000 APRIL 10, **Physician** ROY ARTHUR WHITE 12:08 p.m /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 401 N. MAIN ST GREENSBORO CAROLINE If Under 24 Hrs. 8. Dete of Birth
(Month, Day, Year)
0CT. 1, 1932 If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Days Months 1 M 2□ F Hours MARYLAND 67 Director 217-28-4115 Usual Residence of Decedent death with the Maryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits show pernit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryla Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Nems 23a or 28a-1 show any Injury or other traumatic event, the Medical Example must be not a date. 1 Yes 2 □ No Directo MARYLAND CAROLINE **GREENSBORO** 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 401 N. MAIN STREET 21639 U.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No If Yes, Give 4. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 6 Carpenter agriculture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Roy F. White Alice F. Jarrell 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Frances Marchiano 1839 Oakwood Drive, Melbourne, FL 32935 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Chester Cemetery 4/17/2000 Chestertown, Maryland 21. Signature of Funerel Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME uk 130 Speer Road, Chestertown, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Arteiosclerotic Cardiovascular Disease years Examiner Due to (or es a consequence of): Examiner that the death cartificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): physician tha buna Box 68760. Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown signed t Records, þ The law requires 24b. Were eutopsy findings available prior to completion of cause of death? edical Certification: To Be Completed 24a. Was en eutopsy performed? paga 2 should 1 Tyes 1 ☐ Yes 2 ☐ No of Vital after death.

Director: After this cartification of in by the funeral director, Physician: 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Magner of Death 1 A Naturel 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours To the Funeral I complataly filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number MD. D06804 4/12/00 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) David Stout, M.D. 219 S. Washington St., Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar

APR 14 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MYOH:H ther /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number **Examiner** Queen If Under 1 Yaar 8. Data of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Months Days 1□ M 2X F Yrs 177-10-2138 Director October 1, 1918 Pennsylvania Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mental Hygiena. 7 is marked other than "natural", or items 23e or 28e-f shov traumatic svent, the Medical Exportment must be notified at Yes 2□No Director Maryland Queen Anne's Sudlersville 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 110 South Church Street 21668 United States Funeral Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: by White ₩Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education 18. Mother's Name (First, Middle, Malden Sumema) 17. Fether's Name (First, Middle, Last) Be I end 2 should be fillelith and Mental H Margaret<sub>Seal</sub> Paul Pelter 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 Is Margot Massie - daughter PO Box 95, Sudlersville, Maryland 21668

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date

20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens April 25, 2000 Bel Air, Maryland 22 Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiretory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final reast (once diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physiclan and sthe burial-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): pe Physician/Medicai Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 250No by 24b. Were eutopsy findings eveilebla prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axeminer? Be 26. Place of Deeth (Check only one) Other: 

Surviving Homa 5 Residence 6 Other (Specify) Hospitel: 10 1 Yes 2 H 1 Inpatiant 2 ER/Outpatient 3 DOA this Certification: 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune complataly fi edical (Check only one) 29b. Signature end title of double 29c. License number 29d. Date signed (Month, Dey, Year) 32036 1/2 000

Drue Cherte. Md 21619

State Registrar 30. Name and address of perform to completed cause of death (Item 23a) (Type, Print)

V. Doneho

32. Registrar's Signature

Spran

APR 2 4 2000

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Beatrice Warfield Barrett April 18 2000 8:15pm 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Roland Place Park Baltimore 5. Social Security Number If Under 24 Hrs. If Under 1 Yeer 8. Date of Birth (Month, Day, Year) Jan. 27 1921 Birthpleca (State or Foreign Country) Md. 6. Sex 7. Age (In yrs. last birthday) Deys 1□M 2₩F 79 219-16-0074 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits Baltimore Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 W. 40th Street 21211 USA Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 11. Maritat Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married specify: White 1 ☐ Yes 2 X No Specify: 3 CWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry domestic Elementery/Secondary (0-12) College (1-4or 5+) homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Annie Allen Daniel Barrett, 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carter Stone Warfield (son) 9933 Windflower Dr., Ellicott City, Md 21042 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 □ Cremetion 3 □ Removal from State 4-21-00 Sykesville, Md Springfield Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funeral Service Licensee Paige Haight Deribert P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

physician and a the buriel-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Md

Funeral

Director

"natural", or items 23s or 28s-f show adical Examiner must be politized at

pemit. Peges 1 and 2 should be flied within 72 hours etter death a Department of Health and Meniel Hygiene. Important: if item 27 is marked other than "natural", or itema 23s ents in Injury or other treumatic event, the Medical Examiner mast enter.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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with the Marylend

29b. Signature, end title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

APR 2 0 2000

shock, or heart failure. List only o	olicetions thet caused the deel one cause on each line.	ns. Do not enter the mod	e or cyling, such es cardia	ac or respiratory errest,	Approximate tntervet Between Onset end Deeth
tmmediate Cause (Final disease or condition resulting in death)		touts CV.	A		IMIN
resuming in death)	Due to (a	or es a consequenca of):			1
	b	17 500	0		
Sequentially tist conditions, if any, leading to immediate	Due to (d	or es e consequenca of):			
Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	cDue to (c	or es e consequence of):			
resulting in death) Last	500 (0 (0	51 55 5 551155Q551155 51).			
	d				
Darf II Other significant conditions on	intributing to death but not res	sulting in the underlying o	ause given in Pert I.	23b. Did tobacco uee co	ntribute to the cause of death?
ratit. Other significant conducties co				1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
Part II. Other significant conditions co				24a. Wes en eutopsy performed?	3 Probably 4 Unknown  24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
25. Wes case referred to medical			26. Piece of De	24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
25. Wes case referred to medical	Hospital:	] ER/Outpetient 3 □ DO	Othor: C	24a. Wes en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
25. Wes case referred to medical examiner?	Hospitel: 1   Inpatient 2    28e. Date of tnjury (Month, Dey Year)		Othor: C	24a. Wes en eutopsy performed?  1 Yes 2 No seth (Check only one)	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?  1 □ Yes 2 □ No

29c. License number

29d. Date signed (Month, Day, Year) 00

State

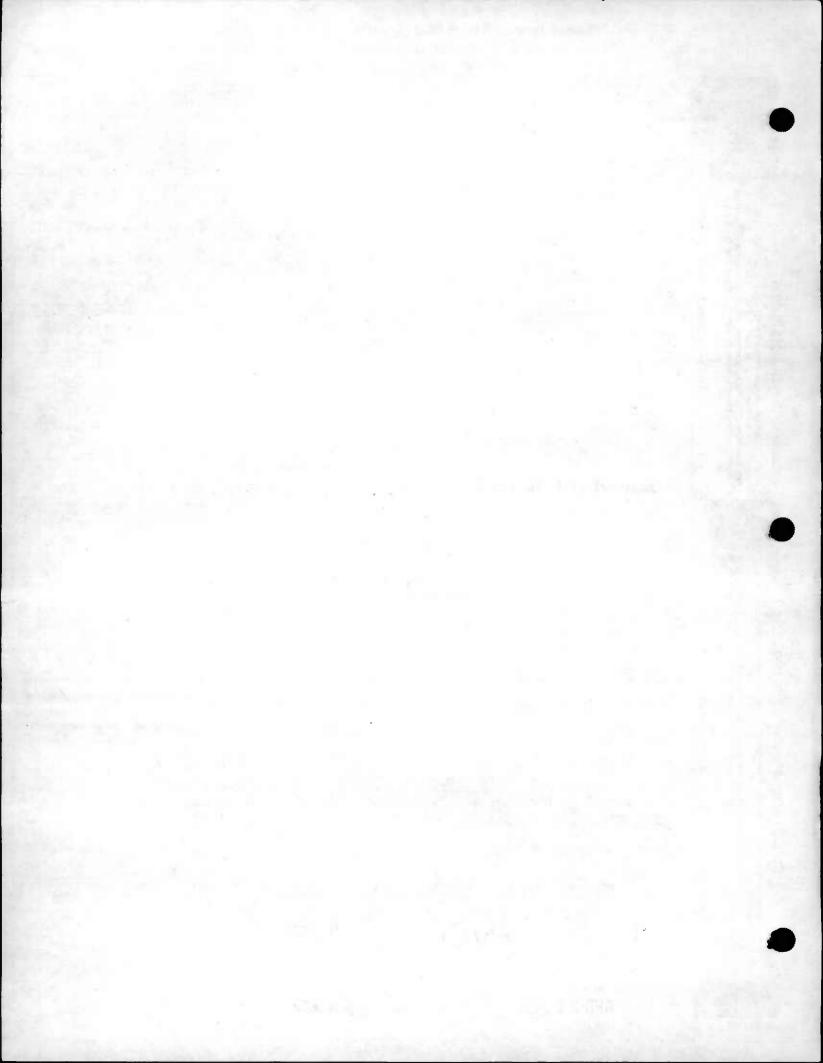
Registrar

To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certifical completely filled in by the funeral director;

Gregory L. Walker M.D. 3333 N. Calvert St., Baltimore, Md 21218

32. Registrer's Signeture



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3 Time of Death **Physician** 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 0540 a.m 28,2000 /Medical 4c. County of Deeth Examiner Sacred Heart Hospital Allegany

9. Birthplaca (Stata or Foreign Country) Cumberland, 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Deys Yrs. Director Maryland 217-10-0376 November 11, 1910 Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show is 1 end 2 should be filed within 72 hours after death with the Meryle of Health end Mentel Hygiene. Ifem 27 is marked other than "natural", or itema 23a or 28a-1 show other treumatic event, the Med cell Examiner must be noutled. 1 Yes 2 □ No Directo Maryland Allegany Cumberland, 10g. Citizen of Whet Country? 710 Shawnee Ave. 21502 Funeral **USA** 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yas, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. 11. Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Dacadant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Bus Driver** City Government permit. Peges 1 end 2 should be file Depertment of Health and Mentel Hy, Important: If Item 27 is marked othe eny Injury or other treuments access 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Webster Yutzv Ella L. (Cougheour) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Joseph F. Yutzy 812 Ashland Ave., Cumberland, MD 21502 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removel from State (Specify) Madley Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 5/1/00 Hyndman, PA 15545 22. Name and Addrass of Fecility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 Approximete Intervel Between Onset end Death 23a. Pert1. Enter the disease, or complications that ca shock, or heart feilure. List only one cause on as ised the death. Do not antar the mode of dying, such es cardiac or respiratory errest, **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Da to (or as a consequence of): Examiner 00 attending physician end for use as the burial-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (o Division of Vital Records, P.O. Box 68760 Physician/Medical as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detact 1 □ Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to complation of causa of daeth? Completed 24a. Wes en eutopsy performed? peen 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Placa of Death (Check only ona) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA Shi 28a. Date of Injury (Month, Dey Year) funeral 27. Menner of Death 28d. Dascribe how injury occurred 28h Time of 28c. Injury et Work? Affer t Certification: ours efter deab.

I Director: Ah.

in by the fur 160 Naturel 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours ef To the Funerel DI completely filled in 15 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) end manner stated. 29e. Certifier Medical 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3 10 20a) (Type, Print) 30. Name end ddress of person who completed cause of death (liter 21502 Mehanna 909-B Seton Drive, Cumberland , MD 32. Registrar's Signatura 31. Dete filed (Month. Dav. Year) State APR 2 8 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

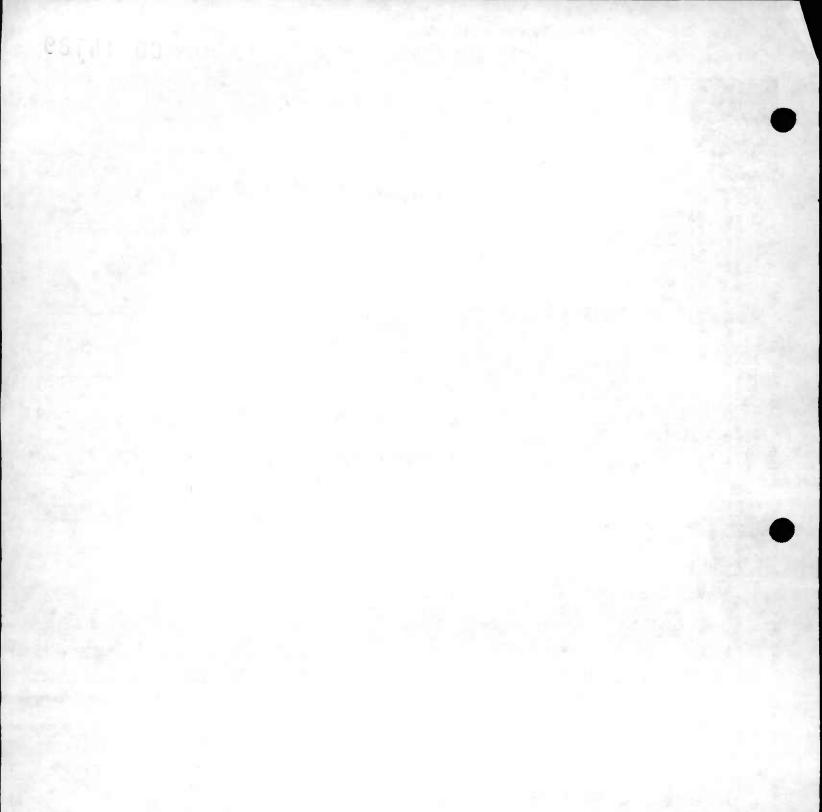
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death CARLOS A. ACOSTA Month May **Physician** 06 2000 00:49 A.M /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 8-25-1983 Birthplaca (Stata or Foraign Country) 5. Social Security Number **Funeral** Months Days Hours 18 M 2□ F Director 638-52-3808 16 EL SÁLVADORE Usual Residence of Decedent with the Merylend 10c. City, Town or Location 10d. Insida City Limits 10a. State 10b. County ral', or flems 23a or 28a-f show Examiner must be notified at ANNE ARUNDEL ANNAPOLIS 1 N Yas 2 No Director 10e Street and Number 10f. Zip Coda 10g, Citizan of What Country? 240 HILL TOP LANE APT 107 21403 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mantal Hyglene. Infortant: if Item 27 is marked other than "natural", or het any Injury or other treumatic event, the Medical Examinate Date. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1X Yas 2□ No Specify: MEXICAN Specify: HISPANIC à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) -8--0-LABORER TILE 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be NICOLAS ACOSTA MARTINEZ MARIA DEL CARMEN 2 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 240 HILL TOP LANE APT 107 ANNAPOLIS, MD. 21403 NICOLAS A. MARTINEZ (FATHER) 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, State Data 20a Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata EL JAGUEY-EL SALVADOR 5-13-2000 LA UNION, EL SALVADORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M 3 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY 821 WEST ST. ANNAPOLIS, MARYLAND 21403 Larry & Tee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Daath **Physician** Immediata Causa (Final disease or condition rasulting in daalh) /Medical Injuries Examiner Examiner that the death certificate be executed ician and bunal-trans Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Cause (Diseasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequanca of): physician the buna Box 68760, Physician/Medical Dua to (or as a consequanca of): 9SH 23b. Did tobacco use contributa to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown of Vital Records, by The law requires 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed hes egeq 1 X Yas 2 No 1 Yas 2 No certificate Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1X Yas 2□ No this 28b. Tima of Injury edical Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred or Attending P After Division 1 Natural 5 Pending investigation 1 ☐ Yas 2 No -5-2000 2052 Motor vehicle erel Director: / 2 Accident accident 6 ☐ Could not be 3 Suicida 281. Location (Straet and Number or Rural Route Number, City or Town, State) Loute 3/Grand Oak 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) datarmined 4 I Homicida To the Hospital or within 24 hours aft To the Funerel Di completaly filled in Annapolis, Manyland Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and title of cartifian 29c. License number O.C.M.E. May 7, 2000 30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print) Stephen adent2 111 Penn Street, Baltimore, Maryland 21201 9 2000 32. Registrar's Signatura Registrar

Buch

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ic	Antonio .	Ashby	State of Maryland /	Department of H Certificate of		ntal Hygiene 🛭 🕻	14789		
	Physician /Medical	Decedent's Name (First, Middle, Last,      ERic      A Facility Nama (If not institution, giva.)	ANTONIO	ASHBY			Year 2000 2:10 P.M.		
	Examiner Funeral Director	University of Mar 5. Social Security Number 6. Sa:	yland Medical C	enter	Baltimor		N/A  9. Birthplace (State or Foreign Country)  MARVLAND		
	p .	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  N			IMORE (	2, Ty	10d. fnside City Limits 1,7⊠ Yes 2 □ No		
20	urs after death with the Maryla all, or thems 23e or 23e+felto Examiner must be notified at by Funeral Director		12. Was Decedent Evar in V,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give	10f. Zip Code  13. Was Decedent of Hif Yes, specify Cubin 1 Yes 2 No	2/229 dispanic Origin? (Specify en, Mexican, Puerto Rice Specify:	Yes or No- an, etc.)  10g. Citizen of V  14. Rac Blac  Specify	e - American Indian, ck, White, etc.		
d 21215-0020	ned within 72 ho typiene. ver then "naturn nt, the Medical I Completed	SENTAGE 4 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		Sa. Decedent's Usual Occup (Giva kind of work done life. DO NOT use retired	PERSON		SLACK usiness/Industry		
Maryland	d 2 should be fit th and Mental H 7 is marked off traumatic aver To Be	EUGENE  19a. Informant's Name/Relationship (Ty RONETTE MOOR		BY 9b. Mayling Address (Street	LAURA and Number or Rural R	oute Number, City or Town,	WHITFIELD State, Zip Code)		
Baltimore,	permit. Pages 1 an Department of Heal Important: it leam 2 any injury or other ance.	20a. Method of Disposition  1 Burial 2 Cramation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	emoval from State  20b. Place ceme  W000	22. Name and Addre JOSE PI 2140 N	METERY 15- Ses of Facility  H. BRO  FULTON	NATE DE LOCATION- (11-00 BALTI. WWW JR. FL AVE. BALTI	MD. 2/228 City or Town, State MORE, MARYLANK INERAL HOME THORE, MD. 2/2/1		
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complished, or heart tellure. List only of Immediate Cause (Final disease or condition resulting in death)	GUMNOT W  Due to (or as				Approximate Intervel Between Onset and Death		
× 68760,	o certificate be executed and inding physician and use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseese or injury that initiated avents resulting in death) Last	Due to (or as	a consequence of): a consequence of):					
Box	deeth e etter ed for	Part II. Other significant conditions cor	tributing to death but not resulting	ven in Part I.	23b. Did tobacco use contribute to the cause of death?				
, P.O.	es that the igned by the be detach by Phy				1 Yes 20 No 3 Probably 4 Uni				
Records,	v requir been s should					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of causa of deeth?		
		25. Was cese referred to medicel			26. Place of Death (C	1 Yes 2 No	1 Yes 2 No		
of Vitai	E E .	INO THE ZUNO		Outpatient 3LI DOA	her: 4 Nursing Home	5 ☐ Rasidence 6 ☐ Oth			
Division	leath. tor: After th the funeral cation:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  6 Could not be determined	28a. Date of Injury (Month, Day Year)  - 3 - 00  28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	Yes 2 No 5	Describe how injury occur  My John WA  Location (Street end Numble City or Town, State)  DOBLY BEWON	and Number or Rural Route Number,		
	24 hourst hourst stely fill dical	29a. Certifier (Check only one)  1 Certifying Physical Examination Check only one)	Iclen: To the best of my knowled ler: On the basis of examination and menner stated.	ge, death occurred et the ti	me, date end place, and	due to the cause(s) and mat the time, date and place,	anner es stated. and due to the cause(s)		
)	To the within comple	29b. Signatura and title of certifier	rethele	29c. Licens	O.C.M.E.		d (Month, Day, Year) 5, 2000		
	State	1100 000 000	mpleted cause of death (Item 23)  LEU W  32. Registrary Signature	111 Penn St	reet, Balti	more, Marylan	nd 21201		
1	Registrar	MAY 0 9 2000	per p. pg	cours					



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey **Physician** Thelma C. Abt 2000 May 11:51 AM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. Dec. 2, 19 Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 M 20 F 212-40-4294 87 Maryland **Director** Usual Residenca of Decedent death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 8800 Old Harford Rd. Apt. 232 21234 U.S.A. Funeral 14. Raca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Department of Health end Mental Hyglene. Important: If liem 27 is marked other than any injury or other treumatic event, the Managas. College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Mary Teidman Harry Francis Ray 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Frederick W. Abt, Ir. 8800 Old Harford Rd. Apt. 232 Baltimore, MD 21234 20b. Ptace of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 D Buriet 2 Cremetion 3 Removel from Stete Gardens Of Faith Cemetery 5/8/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd. Baltimore, MD

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset end Deeth **Physician** Immediate Cause (Final diseese or condition resulting in deeth) /Medical MYOCARDIAL INFARCTION HOUR Examiner Due to (or es e consequence of) Examiner or Attending Physicism: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) and P.O. Box 68760, Physician/Medical thet Initieted events resulting in deeth) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ate has been signed by page 2 should be detac Division of VItal Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed's 1 Yes 1 Yes 2 No Be 25. Wes case referred to medical 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 8 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation Natural s after deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and 29c. License number 10 MMY 5, 2000

Registrar
DHMH 16 Rev 6/95

8813 WALTHAN WOODS

P), BUTTWORE, MI)

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

9 2000

N

32. Registrer's Signeture

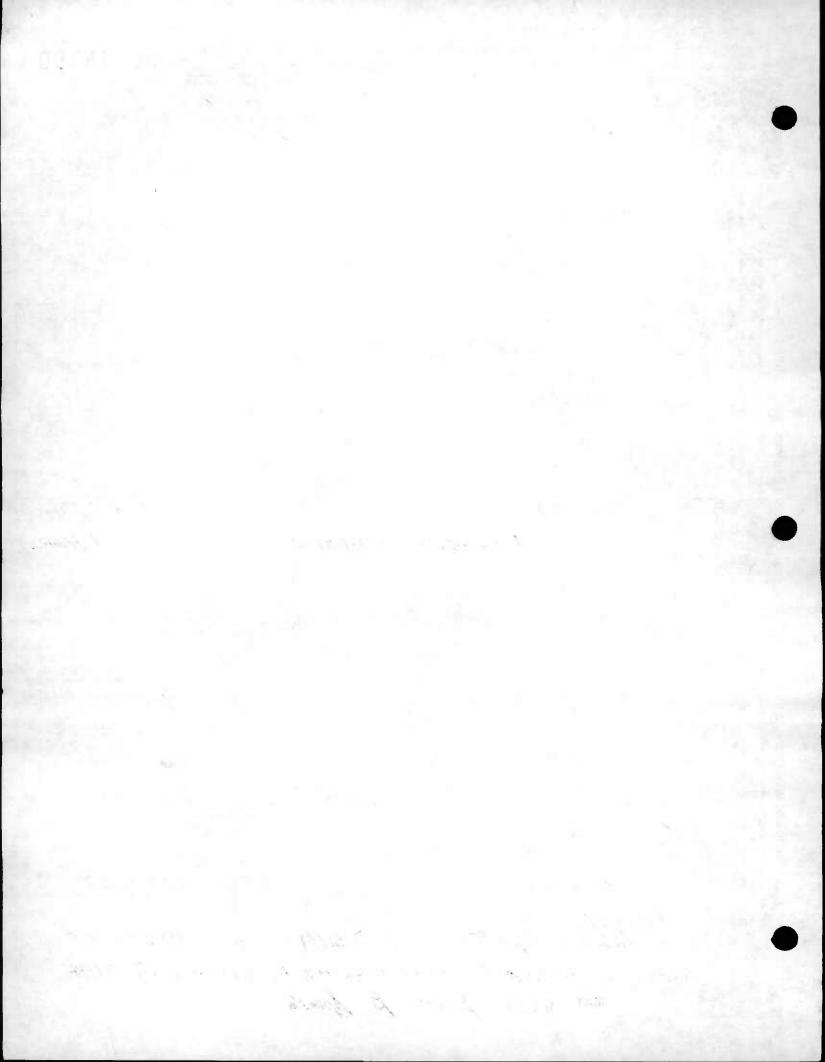
MININSOMY,

MICHARI

State

31. Dete filed (Month, Dey, Year)

MAY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MAY 6, **Physician** ANNE ALPERN 2000 3:40 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, giva street end number) 4c. County of Deeth Examiner NEWPORT ASSISTED LIVING REISTERSTOWN BALTIMORE 8. Date of Birth (Month, Dey, Yeer) OCT. 7, 1 If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Yeer 6. Sex 7. Age (In vrs. lest birthdev) Birthplace (Stete or Foreign Country) **Funeral** Deys 1□M 2XF Months 212-22-5883 Yrs. 1905 Director Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 1 ☐ Yas 2 No Director MD BALTIMORE REISTERSTOWN 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? me 23a 64 MAIN STREET 21136 U.S.A. Funeral death 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decadant Evar in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours effar an nent of Health and Mental Hygiene.

ant: If Item 27 ie merked other than "natural", or itei ary or other traumatic event, the Medical Examine. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Saltimore, Maryland 21215-0020 1 ☐ Yes 2√€ No Specify: Specify: þ WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondery (0-12) College (1-4or 5+) OWNER RETAIL 17. Fethar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surname) SAMUEL COHEN MAMIE T. COHEN 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) ELWIN ALPERN / SON 3439 PHILIPS DRIVE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) MOSES MONTEFIORE WOODMOOR 5/8/00 BALTIMORE, MD 22. Nama end Address of Fecility 21. Signatura of Funaral Sarvice Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** CARDIAC ARRETHMIA /Medical Immediate Cause (Final disaase or condition rasulting in death) Examiner Examiner sician end burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Last Box 68760 Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of death? 1 Yes 2 Ne 3 Probably 4 Unknown Cardio vos an Records, Completed by

24b. Wera autopsy findings aveileble prior to completion of cause of deeth? 24a. Was an eutopsy performed?

25. Wes case referred to medical examinar? 250 No 1 Yes 27. Menner of Deeth

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) LUING

1 ☐ Yes 2 ☐ No

1 Neturel

3 Suicida

4 Homicide

Be

After this

To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al complately filled in by the fu

edical Certification: To

5 Pending investigation 2 Accident 6 ☐ Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Assisted 28d. Describe how injury occurred

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and menner es steled.
2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner steled. 29b. Signeture end title of certifier

29c. License number D-16090 29d. Date signed (Month, Day, Year)

30, Name and address of person who completed, cause of deeth (Item 23a) (Type, Print)
Herbert Serold Osten HD 3635 Old Court Rd - Pleasuille Hd 21208

Registrar

31. Dete filed (Month, Day, Yeer) MAY 0 9 2000 32 Registrer's Signeture south

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

**DHMH 16 Rev 6/95** 

of Vital

Division

or Attending

death.

1864 - The Transley Johnson Street, The and the best will be

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 | 4792

Certificate of Death

Reg. No.

Physician			Certi	ificate of I	Jeani	Re	g. No.		100
Physician	1. Decedent's Neme (First, Middle, I	Last)				2. Date of Deeth Month		Year 3	. Time of Death
/Medical	BAYMOND	P.	BUETT	NER		MAY	4,20		4:45 PM
Examiner	4e Fecility Neme (If not institution, g	rive street and number)		4	b. City, Town, or L	ocation of Deeth	4c. County o	f Deeth	
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or 28a-f show be notified at Director			DA TIME						1 des 2 No
or 28a-f • be notified Director	10e, Street end Number		BALTIMO	10f. Zip Code		10	g. Citizen of W	hat Country	7
		~ A W			234				
era	3317 CHESU	12. Wes Decedent Eve	r in U.S. 13. W			pecify Yes or No-		S.A.	Indian.
r ttems 23. direc rount Funeral	1 Never Married 2 Merried	Armed Forces?		_	ispenic Origin? (S n, Mexican, Puert	Rican, etc.)	Bleck	, White, etc.	
by by	3 Widowed 4 Divorced	If Yes, Give	emy 10	Yes 20 No	Specify:		Specify:	WHI	TF
r, tre Medical r. Completed	15. Decedent's	Education	16e. Deceder	nt's Usuel Occup		1	6b. Kind of Bus		
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event Be C	17. Fether's Neme (First, Middle, Las	st)			18. Mother's Nan	ne (First, Middle, M	a <i>iden Suma</i> me	)	
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27 in	ANDREW CAMPE	BELL NEPHE	N 5312	W. HEAF	S RD.	PYLESV	IUE.	1D. 2	1132
E do	20e. Method of Disposition		20b. Place of Disposit	ition (Neme of etory or other plea		Dete 2	Oc. Location - 0	City or Town	State
4 5	1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec		THEOENS C		11	2000	eoseor	ATF. A	AN
mportant: any injury anse.	21. Signeture of Funeral Service Lic			Name end Addres		VANS P			
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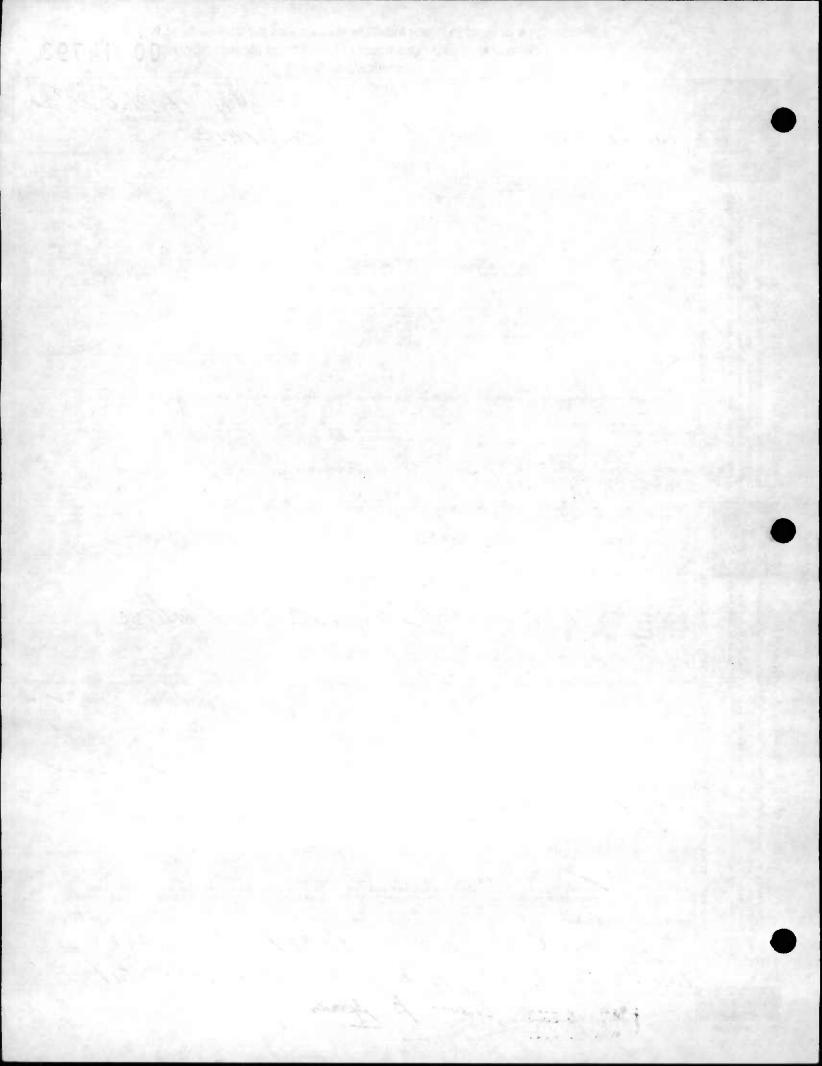
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urs efter al., or its Evantine by Fui	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,9 Armed Forces?  1 Yes No No If Yes, Give Year or Detes:		Decadent of I- s, specify Cub Yes 2 No	Hispenic Origin? (San, Mexican, Puel Specify:	Specify Yes or No to Rican, etc.)	14. Raca Blac Specify	a - American Indien, k, White, etc. Black
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d other event, Be C	17. Father's Name (First, Middle, Last)							
To Bitch			anita 1					
27 is m	19e. Informent's Name/Relationship (Ty Juanita Wilson/	Mother			and Number or F oat St.			Stete, Zip Code) MD 21217
or other	20e. Method of Disposition  1 Buriel 2 Cremation 3 R  4 Donetion 5 Other (Specify)	lemoval from State	lece of Disposition ametery, cremetor	n (Neme of ny or other pla	-	Date	20c. Location -	City or Town, Stata
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V State of M	29b. Signature and title of certifier  Ferry . 1	Cal M mpleted cause of Senath (Item	. D.	Sec. Licens	349		5 4	(Month, Day, Year)
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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \( \int \) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 6, Joseph Francis Barnhouser May 6
4b. City, Town, or Location of Death 2000 6:00PM /Medical 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 832 Creek View Road Severna Park Arundel Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 26, 15 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□ F Yrs. 79 215-12-9692 Director Maryland Usual Rasidenca of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exercises. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Severna Park Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 832 Creek View Road 21146 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 12. Was Decedent Evar in U,S.
Acroed Forcas?
1 △ Yas 2 □ No WW II 14. Race - American Indian. Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify White Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Steel Worker Steel Corporation 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Surnama) Unk. Agnes Toliegeski 19a. Informant's Neme/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joanne F. Hyson/daughter 832 Creek View Rd., Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Steta 4 Donation 5 Other (Specify) Metro Crematory, Inc.5/8/00 Baltimore, MD 21. Signature of Funaral Sarvice Licenses Signs les 22. Name and Address of Eacility Cremation Society of Maryland, Inc. Gregorchik Edward A. 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical · nonsmall cell lung cancer Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be assected within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the itmental director, page 2 should be deteched for use as the burnal-transit completely filled in by the funeral director, page 2 should be deteched for use as the burnal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or es e consequence of): Division of Vital Records, P.O. Box 68760, that initiated evants rasulting in death) Last Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by page 2 should be detact 1 2 Yee 2 No 3 Probably 4 Unknown Be Completed by 24b. Ware autopsy findings available prior to complation of cause of death? 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Medical Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signatura and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) ,2000 022782 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) South Hunover Street Battinary, Muryland 21230 Berkman w nio 3001 31. Data filed (Month, Pay, Year) 32, Registrar's Signatura

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Registrar

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price.	21. Signature of Funeral Service License and License and Address of Facility Cremation Society of Maryland Edward A. Gregorchik 299 Frederick Rd. Baltimore,									and,	Inc. D 2122		
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ORIGINAL

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			C	ertificate	e of Death		Reg. No.	14796	
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/Medical	HARV	- 1111	NARD	<b>S</b>	th Oit. Your ca	MAY		2000 10.05 am	
Examiner	4a Facility Neme (If not institution, giv		4b. City, Town, or		th 4c. County of				
uneral irector	5. Social Sacurity Number 480-05-6239	Sex 7. Age (In yr.				8. Date of Bi		B. Birthplece (Stete or Foreign Country) ew Hampshire	
	Usuel Residence of Dacedant					TODIT -	7, 1705 11	ew mamponitie	
fledat	Maryland Howard		City, Town or $Ellic$	ott C	ity			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
il Direc	10e. Street end Number 3004 N. Ridge	Road	9	10f. Zip 2	Code 1043		10g. Citizen of Wh	et Country?	
Tatural, of tems 23s of 28s-f show added Examiner must be notified at letted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedant Ever in Armed Forces? 1 ☑ Yas 2 ☐ NoW W If Yes, Giva Yeer or Detes:	U,S. 13	3. Was Deced If Yes, spec	lent of Hispenic Origin? (§ ify Cuben, Mexicen, Puer XXI No Specify:	Specify Yes or N to Rican, etc.)		Americen Indian, Whita, atc. White	
	15. Decedent's E (Specify only highest gre Elamentery/Secondary (0-12)	ducation eda completed) College (1-4or 5+)	16a. Dec (Gir lifa	cedent's Usua va kind of wor i. DO NOT us	al Occupation rk done during most of wo sa ratired)	orking	16b. Kind of Busi	ness/Industry	
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To Be Comp	17. Fether's Neme (First, Middle, Last,						, Maiden Sumema,		
To	Harry Everett					arion H			
or traum	19a. Informent's Name/Reletionship ( Margaret B. Stubb	s/daughter	122	7 Par	(Street and Number or R k Ave., Ba				
inportant: It rent 27 is marked outer until his Injury or other traumatic event, the Mode.	20a. Mathod of Disposition  1 □ Buriel 2 ▼ Cramation 3 □ 4 □ Donation 5 □ Other (Specification)	IMemoval from State		position (Nam rematory or of Cremato		Data /6/00		ore, MD	
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sician	23a. Part 1. Enter the diseesa, occom shock, or haart failura. List only		ath. Do not e	enter the mode	e of dying, such es cardia	c or respiratory	errest,	Approximeta Intarval Batween Onsat end Daath	
ledical aminer	Immediata Causa (Final diseese or condition resulting in deeth)	. RESPIRA	TORY	FI	ALURE			ZWEKS	
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for use es th	resulting In death) Last	a Dyspha		equerice oi).		4 months			
d for use	Part II. Other significant conditions of	ontributing to death but not re	esulting In the	underlying ce	euse given in Part I	23b. Dic	tobacco use cont	ribute to the cause of death?	
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completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kr niner: On tha basis of examin end mennar statad.	nowledge, da nation and/or	eth occurred a invastigation,	at the time, date end plac- in my opinion, daath occ	e, and due to the urred et tha tima	a ceuse(s) and man , date and place, ar	nar as statad. d dua to tha causa(s)	
Me	29b. Signatura and title of certifier			29c	. Licanse number		29d. Data signad	(Month, Dey, Year)	
(0	1 Whonk	out MD.			D31331	W A T	MAY.5	h 2000	
4	30. Neme end address of person who					UKAT	MO		
Ctata	10802 HCKOR 31. Date filed (Month, Day, Year)	Y ROGE  32. Registrer's Sign	RD nature	COWA	NBIA MD	210	14		
State	MAY O	0000 1 60	na/	A	hook				

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 14797 Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death April P Month , **Physician** 8.18 AM William Branch 25 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, ος Location of Death 4c. County of Death **Examiner** Baltimore Hospital Center Harbor N/A Months Days Hours Min. Jan 1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-07-5305 18 M 2□ F unk 90 Yrs Director Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylai Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show enty hydroy or other treumstic avent, the Maddal Examiner pust be notified an entitie. 11 Yes 2 □ No Director Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? IISA 21230 1213 Light Street Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yas, Giva unk Year or Datas: 1 Navar Marriad 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) unk unk 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital Center 3001 S. Hanover Street Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removed from Stata 4 Donation 5 Other (Specify) In State Bonald S. Wade, Director 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 234. Part1. Entar the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shick, or haart failure. List only one cause on aach line. Approximete Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) Sepsis /Medical day s **Examiner** Examiner rac requires that the deeth certificata be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last Records, P.O. Box 68760. physician Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Pheumonia intake 1 Yes 2 No Poor Oral 1 ☐ Yes 2 10 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerel Director: After this certifics completely filled in by the funeral director, i 25. Was casa ratarred to medical exeminar? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 (4) Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? edical Certification: 28b. Tima of 28d. Describe how injury occurred 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one)

State Registrar

29b. Signatura and title of certifian

31. Data filed (Month, Day, Year)

Mohanad

Methanad

Bakl

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

MD

2000

32. Registrar's Şignatura

**DHMH 16 Rev 6/95** 

29c. License number

3001 Southhanover Street, Baltimore, MD 21225

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'e Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** Cloris E. Boddie May 3:45am 04, 2000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 5004 Moravia Road Apt. "B" Baltimore 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 12-05-59 6. Sex 7. Age (In vrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 10 M XXF Months Hours 40 215-78-7562 MD Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits X Yes 2□No Baltimore MD NA Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA Apt. "B" 21206 5004 Moravia Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Bleck, White, etc. XXNever Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: Black ò 3 Widowed 4 Divorced Yeer or Detes Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Baltimore City Sch Custodian 12th Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Jenkins Mary Boddie Arthur 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 5004 Moravia Road Apt. "B" Baltimore, MD. Christina R. Woolard 20b. Place of Disposition (Name of cemetery, cremetory or other p 20c. Location - City or Town, State MD. 20e. Method of Disposition Date N Buriel 2 ☐ Cremetion 3 ☐ Removel from State King Mem. PK. Cemetery 05-10-2000 Randallstown 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediete Ceuse (Final diseese or condition resulting in death) /Medical HEPATIC ENCEPHATOPATH Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown HIV Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Box 68760. P.O.

The law requires that the deeth certificate be executed signed by the or Attending Physician: this s after deeth.

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or items

Peges 1 and 2 should be filed within 72 hours after d ann of Health and Mental Hyglene. ann if New 27 ie merked other than "netural", or then rry or other traumatic event, I'm Medical Engine rry or other traumatic event, I'm Medical Engine

permit. Peges Depertment of Important: If It any Injury or or

Baltimore, Maryland 21215-0020

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Division of Vital Records. filled in by apital chours a

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Division of V	To the Hospital or Attending Physic within 24 hours after deeth.  To the Funeral Director: After this or completely filled in by the funeral directions.	Medical Certification: To
7	JR 5	
	S1	tate trar
	Renie	rar

29b. Signeture end title of certifier HUA

5 Pending investigation

6 ☐ Could not be

25. Wes cese referred to medical examiner?

1 Yes

27. Menner of Death

Neturel 2 Accident

3 ☐ Suicide

29e. Certifier (Check only

4 Homicide

No No

28e. Dete of Injury (Month, Dey Year)

29c. License number

28c. Injury et Work?

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner steted. 29d. Date signed (Month, Dey, Year)

Residence 6 Other (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

28d. Describe how injury occurred

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home

1 Yes 2 No

ed ceuse of deeth (Item 23a) (Type, Print) 30. Neme end eddress of person who complete 600 NORTH WOLFE S NEET BAYMORE, MARYLAND 21287 M.D.

32. Registrer's Signature

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

from to shows

MAY COLL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4799 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Yaar HARRY PALMER BURKHOLDER JR. **Physician** MAY 2000 9:21 pm /Medical 4b. City, Town, or Location of Daeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 8620 Kelso Drive Essex Baltimore If Under 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Yaar 8. Data of Birth (Month, Day, Yeer Feb. 2 1925 Birthplaca (Stata or Foraign Country) 7. Aga (In vrs. last birthday) **Funeral** Months Deys 1₽M 2□ F 225-24-8122 75 Director Virginia Usual Rasidance of Decedent deeth with the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f show idical Examiner mast be notified at MD Baltimore Essex 1 Yas & No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 8620 Kelso Drive 21221 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Process Black, Whita, atc. 1 Yas 2 □ No If Yes, Give 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yas 2X No Specify: Specify: þ 3 ☐ Widowed 4 D Divorced Yaar or Datas: Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist MArtin's 12th 17. Fathar's Name (First, Middle, Last) 18 Mothar's Nama (First, Middla, Maidan Surnama) Be HArry Palmer Burkholder Sr. Frances Burkholder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) June Morfe / daughter 1003 Hart Road Baltimore MD. 21286 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from State Metro Crematory Inc. 5/9/2000 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore MD 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221 23a. Part1. Entar the disease, or corp. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List and one cause on each lina. Approximata Interval Between Onset end Death **Physician** Immediata Cause (Final diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner Carcinoma years 0 ettending physician end for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immedieta cause. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in daath) Last Dua to (or as a consequance of) Records, P.O. Box 68760 Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detect 1 Yes 2 □ No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of ceuse of daath? 24a. Was an autopsy Be Completed this certificate hes 1 Yas 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was cesa rafarred to medicel axaminar? 26. Place of Death (Chack only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) edical Certification: To 1 Yas 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Deeth 28d. Dascribe how injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No invastigetion hours efter death. 2 ☐ Accident Director: A 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 3 ☐ Suicida 28f. Location (Straat and Number or Rurel Routa Number, City or Town, Stata) 4 Homicida

Division of Vital To the Hospital o within 24 hours of To the Funeral D

> State Registrar

completely

31. Dete filed (Month, Day, Year) MAY 0 9 2000

29b. Signature and tiple of certifier

(Check only one)

Shock MD Militello Trauma 32. Registrer's Signatura

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to tha causa(s) and mannar es stetad.

22 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the causa(s) and manner stated.

29c. Licansa number

29d. Data signad (Month, Day, Year)

225. Greene ST. Baltimore, MD 21201

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 0910 **Physician** H9-LEN BULGEN 04 2000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner HOSPITAL GOOD SAMARITAN BALTIMORE BAUTIMORE Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 X F Deys Yrs. Director 220-05-1769 Maryland Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10e. Stete 10d. Inside City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 3 any injury or other traumatic event, the Modical Examiner must be nonce. 3905 Parkside Drive 21206 S. A. Funerai 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 € No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Yeer or Dates Specify: ò 3 XWidowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 8th Grade Factory Employee Glass Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Nathaniel Arthur Payne Mary E. Kirchner 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 3905 Parkside Drive, Baltimore, Maryland 21206 John Joseph Payne (Brother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/6/00 Holy Rosary Cemetery Baltimore, Maryland 22. Name end Address of Fecility Schimunek Funeral Home Inc. 21. Signature of Funerel Service Licensee Mais 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. Approximete Intervel Between **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical SEPSIS Examiner Due to (or es e consequence of): Physician/Medical Examiner ACUTE HEIPATIC FAIWRE The law requires that the death certificate be executed attending physician and for use as the bunal-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ is certificate hes been sig director, page 2 should t 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 20 No Hospital or Attanding Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Natural efter death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide To the Hospital of within 24 hours of To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number M.D. Anunag P12561 MAY 04,2000

State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Day, Year)

9 2000

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) MARITAN HOSPITAL, 5601 WCH ANURAC COUPTA MD RAVEN BOULEVARD, BALTIMORE, MO-21 BOULEVARD, BALTIMORE, M7-21239 32. Registrer's Signature

Turk Shirt S. Phar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jane Braunschweiger April 28 22:39 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Howard County General Howard Columbia If Under 1 Yeer | Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) **Funeral** 1 M 2 F Yrs 85 373-32-1200 Director May 19, 1914 Scotland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or itams 23a or 28a-f ahow Examiner must be notified at 1 Tyes 21 No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 1130 Elm Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after a loppartment of Heelth and Mantel Hygiena.

Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic avent, the Middle I aminations. 1 ☐ Never Married 2 ☐ Married White 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad 12 0 Accounting Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be James Newton Gilmour Izabella (Unknown) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Lesniewski / Niece 1130 Elm Road, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from State Meadowridge Mem. Park 5/3/2000 Elkridge, Maryland Donation 5 Other (Specify) Funeral Service License 22. Name and Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Perff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approxim*a*te Interval Between Onset and Death Physician /Medical Immediate Cause (Final Syncopal episode - prob arrhythmia hours disease or condition resulting in deeth) Examiner Due to (or as a consequenca of): Examiner Respiratory Depression & Failure - possible stroke hours the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of): Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐XUnknown 0 Alzheimers Disease, Hypertension, Strokes Records. þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Right hip fracture (4/28/00) with syncopal episode The T 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☒ No Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 ☑ Yes 2 ☐ No 1 ☐ Inpatient 2 ≦ ER/Outpetient 3 ☐ DOA o this 28e. Dete of Injury (Month, Day Year) Apr 28, 2000 Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division Attending 1 Netural safter de. 1 ☐ Yes 2 No fell to floor with loss of 8:00 P M 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete)
2827 Quail Check Ct City MD 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide ò a home 2827 Quail Check Ct 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted. 21042
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only within 7 å 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number W

State Registrar

**DHMH 16 Rsv 6/95** 

31. Date filed (Month, Day, Year)

MAY 0 9 2000

Patryce A. Toye, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

4565 Hemlock Cone Way, Ellicott City, Maryland

21042

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14802 Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Margaret L. Barnes May 7 2000 0458 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Genesis Eldercare - Spa Creek Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. Months Deys Hours Min. March 2,1910 5. Social Security Number 9. Birthplece (Stete or Foreign Country) Maryland 7. Age (In yrs. last birthdey) **Funeral** Months 1 M 2 F 217-72-5937 90 Yrs. Director Usuel Residenca of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits show Hem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at ¥XYes 2 □ No Directo MD Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 308 Locust Avenue 21401 Funerai permit. Pages 1 and 2 should be filed within 72 hours after deat, Department of Health and Mental Hygiena. Important: if them 27 is marked other than eny injury or other traument. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decadent Ever in U,S. Armed Forces?
1 ☐ Yes 2X No
If Yes, Give
Yeer or Detes: 14. Rece - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Thomas Edward Robbins Lucia Adele Geekie 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charles G. Barnes (Son) 1245 Pine Hill Drive, Annapolis, MD 21401 05/10 2000 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Bluff Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD of Funeral Service Lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that daused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Physician /Medical Immediate Ceuse (Final Nephrusilerus. diseese or condition resulting in death) Exami er conjective heart failure Examiner iclan and bunai-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Box 68760. 15 chemic Physician/Medical Due to (or es e consequence of) for use as 23b. Dfd tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Records. þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? certificate has b 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical exeminer? Be funeral director 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Naturel 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely lilled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner steled. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of confider 5/8/2000 032036 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Durato Drive Chester ong 21619 GanyJ ., MI) 31. Dete filed (Month, Dey, Year) MAY 0 9 2000 32. Registrer's Signety State Registrar

XX.

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death 150272 1:20 pm 1 Anganet 2000 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth CANG RUXON NUNSING BARTHONO BATHORE (done 7. Age (In yrs. last birthday) Hours Min. 8. Date of Birth (Month, Pey, Year) Feb. 3, 1923 If Under 1 Year 5. Sociel Security Number 6. Sex Birthplace (Stete or Foreign Country) 219-10-1458 1 M 2 XF Months Days 77 Yrs MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ XNo Baidin 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4711 Carroll Manor Road 21013 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Personnel Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) George Edward Beltz Mary Alice Simmons 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 1030 Gist Road Westminster, Md. 21157 Joan Bair 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Serv 5/9/00 Hampstead, Maryland 21. Signature of Funeral Service License 22. Neme end Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) OTESE CANCON Not Available Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es a consequence of): thet initieted events resulting in deeth) Last Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Multiple embolic ce rebroubult recidents 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2€ No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Disturel 5 Pending investigation

Physician /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

Director

ral', or items 23s or 28s-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Introportant: If them 27 is marked other than "natural", or its any injury or other traumatic event, the Medical Examine once.

Baltimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

The law requires that the death certificete be executed burial-tren ettending physician for use as the buria signed b cate has t certificate this After this funeral of

Records, P.O. Box 68760,

Division of Vital

Examiner Physician/Medical þ Completed Be Medical Certification: To To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After it completely filled in by the funeral

State Registrar

29b. Signature end title of certifier

6 Could not be determined

29c. License number 1)18758

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Day, Yeer)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause at death (Item 23a) (Type, Print) 9660 Belma Road, BAzh were M BARTIMORE ord

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

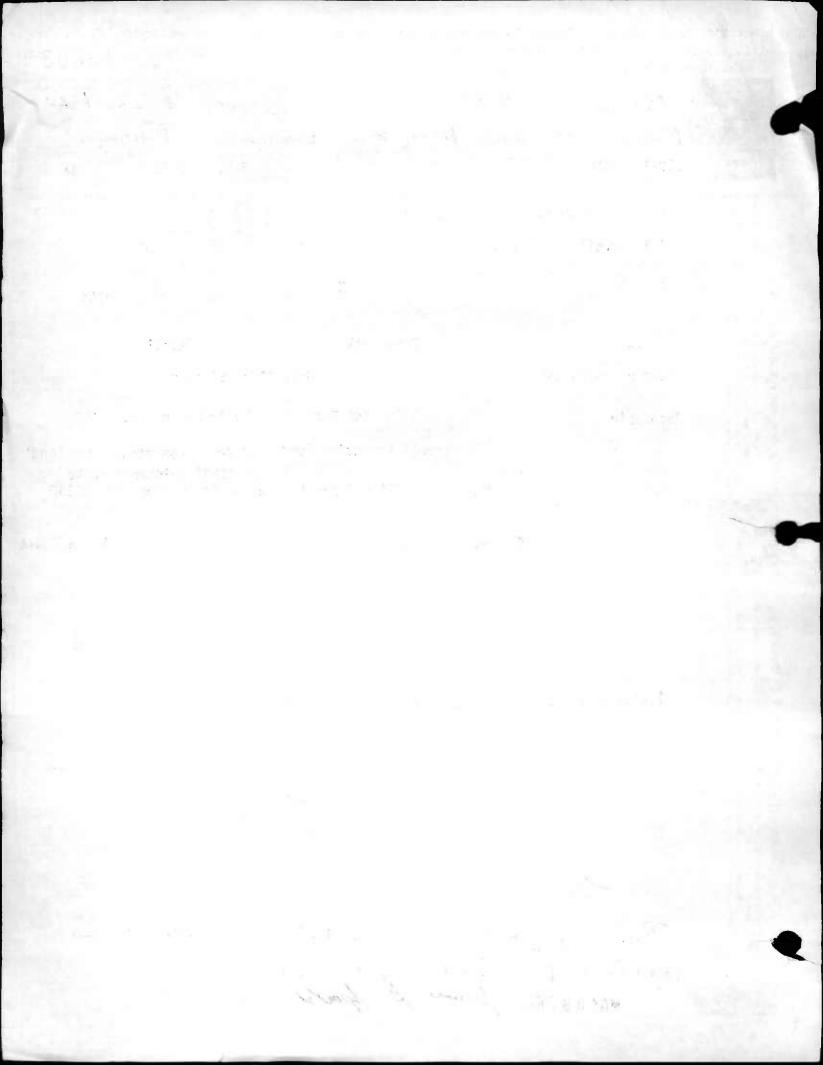
29a. Certifier

4 Homicide

MAY 0 9 2000

32. Registrer's Signature

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14804 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Day Month **Physician** BENJAMIN BECKER 2000 MAY 4, 11:50 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Under 1 Yes 8. Date of Birth (Month, Dey, Year, AUG. 5, 1 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1⊠M 2□ F Yrs 92 N.Y. Director 216-09-1009 Usual Rasidance of Decedan 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code ò 117 OLD PLANTATION WAY 21208 or Items 23a U.S.A. Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. lied within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Giva Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à Specify: WHITE 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedant's Educetion (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coilege (1-4or 5+) BOOKKEEPER RETAIL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental (UNKNOWN) To **ABRAHAM** BECKER SADIE 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) . Department of Health a Important: If Item 27 is any Injury or other tras WENDY PORTER / NIECE 117 OLD PLANTATION WAY - BALTIMORE, MD 21208 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cremetion 3 XRemoval from State BETH DAVID CEMETERY 5/7/00 ELMONT, NEW YORK 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Entar the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Ugscolar accident Examine Dua to (or as a consequence of) Examiner Dementio physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiete ceuse. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai Due to (or as a consequance of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of geath? 1 Yes 2 No 3 Probably 4 Unknown Sacrom Division of Vital Records. þ 24b. Ware autopsy findings aveilable prior to completion of ceuse of death? 24a. Wes an autopsy Completed page 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours efter deeth. Be 25. Was case referred to medice 26. Place of Death (Check only one) Othar: 45 Nursing Home 5 Residence 6 Othar (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Dey Year) 27. Manner Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending invastigation 1 Yes 2 No 2 Accident Director: / 6 Could not be datamined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by the 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar statad. 29d. Data signed (Month, Dey, Year) 29c. Licensa number 29b. Signetu cause of deeth (Item 23a) (Type, Print) 1838 Varela vicenetlee 19 32. Registrar's Signature 31. Date filed (Month, Dey, Yes State MAY 0 9 2000 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

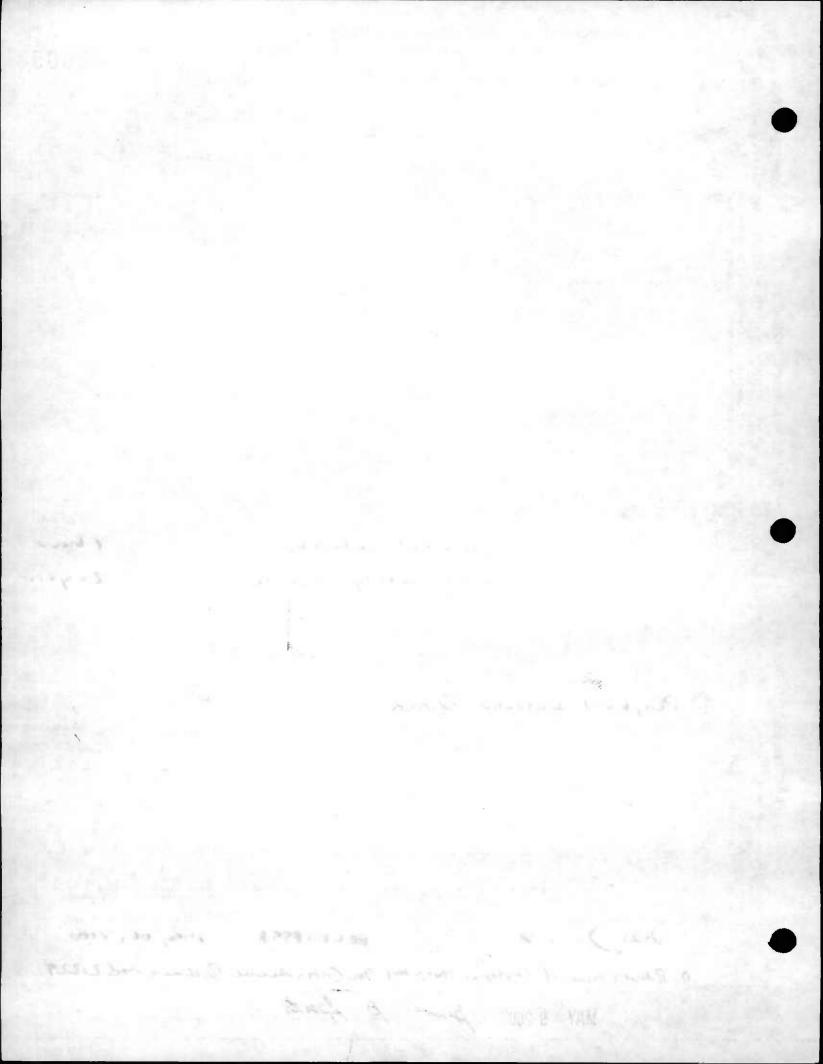
Certificate of Death

4	8	0	2

				Ceni	ticate of	Death		Reg. No.		1 100	
1. Decedent's Name (First, Middle, Last)							2. Dete of De Month	Day	Year	3. Time of Deel	
4a Facility Mana //d	George H. Clark, Sr.  4a Facility Name (If not institution, give street and number)						MAY Location of Deal		000	3:40 P.	
Manager of the same	4a Facility Name (If not institution, give street and number)  St. Agnes Hospital						ore	,	N/A		
5. Social Security Nu			Age (In yrs. las		If Under 1 Year	If Under 24 Hrs	8. Date of Bi		9. Birthp	lace (State or For	
215-05-63	386	1 2 F	81		Months Days	Hours Min.		29,1918	Mary		
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Maryland 10e. Street and Num					10f. Zip Code			10g. Citizen of V			
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/Sagail	15. Decedent's Ed	ducation		16e. Deceder	nf's Usual Occu	pation	rkina	16b. Kind of Bu	usiness/Inc	lustry	
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1 ဩ Burial 2 □	Cremation 3	Removal from Sta	cem	etery, crema	tory or other pla						
4 ☐ Donation 5	5 Other (Specifical Service Lieur		Loude		k Cemet		5/11/00	Baltim	ore,	MD	
Sh	0 0 110	MI	(			ess of Facility neral Hon				0100=	
2719 Hammonds Ferry Road Lansdowne, MD 2122  23a. Pert1. Enter the disease, or complications that caused the dear point enter the mode of dying, such as cardiac or respiratory errest, Approximation interval interval interval.											
shock, or heart	t failure. List only	one ceuse on eac	h line.	DO NOT ONLO	the mode of dy	ing, such as cardia	c or respiratory e	arrest,		Approximete Interval Between Onset end Deet	
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disease or condition resulting in death)  e. My cardial .ntarchion									1 01001		
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Sequentially list conditions if any, leading to immoduse. Enter Underly Cause (Disease or in that initiated events	mediete tying										
that initiated events resulting in death) La	asf	C	Due to (or as	or as e consequence of):							
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Peniph	val v	1ase-la	- D.	Directe				1 Yes 2 No 3 Probably 4 Un			
Part II. Other elgnific							24a Wa	a. Was en eutopsy 24b. Were autop		ere autopsy findir	
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25. Was case referre examiner?		Hospital:	ation who	2/Outpotions	3[] DOA   OI	her:	ath (Check only		or (Casal	v)	
27. Manner of Deeth		1 □ Inp	niury 28	NOutpatienf  Bb. Time of	3□ DOA 28c. Inju	4 Li Nursing i	,	idence 6 Oth		77	
1 ☑ Natural 2 ☐ Accident	5 Pending investigation		Day Year)	Injury		ork? ]Yes 2∐No					
3 ☐ Suicide	6 Could nof b	e 28e. Piece of	Injury - At home	e, farm, stree		office 28f. Location		cation (Street and Number or Rural Route Number			
4  Homicide		building,	, etc. (Specity)								
29a. Certifier (Check only 2	1 Certifying Ph	nysician: To the be	est of my knowle	edge, deeth o	occurred at the t	ime, dete end plec	e, and due to the	cause(s) end me	enner es si	eted.	
(Check only 2 Medical Examiner: On the basis of examination end/or investigations)  and menner stated.						1110	2.70G Ø[ [II Ø [III] Ø				
	data of on siding					se number	,	29d. Date signe			
29b. Signature and ti	me of centiller	1212						16762 63	- 1		
	me or certifier	no			BG-5	848998		1-17	6, 6	100	
29b. Signature and ti	)-	completed cause	of death (Ifem 23	3a) (Type, Pr	BG-S	848998		, 114	4.	7 172 6	
29b. Signature and ti	ess of person who	completed cause of	of death (Ifem 2)	3a) (Type, Pr	BG-5 int) 400 C	948998 ahn Au	ne Ba	16-10-1	me	21229	
29b. Signature and ti	ess of person who	completed cause of StAG	of death (Ifem 2:	3a) (Type, Pr 5/- '+9 /	B6-5 900 C	848948 atm Au	ne Z	16-10-1	nd	2129	

DHMH 16 Rev 6/95

CLARK, GEORGE



Registrar

State

29b. Signature

30. Name and

1056

Vestan

32. Registrar's Sign

29c. Licansa number OCME

on who completed cause death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

APRIL 29, 2000

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

4807 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** COLLINS MAILLIAM 12.25pm EDWARD MAY 4,2000 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hospital. SECOUR Baltimore BON If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Yeer) Sept. 20,1922 Birthpleca (State or Foreign Country) Funeral Deys 1₺M 2□ F Months 76 Director 215-14-0901 Maryland Usuel Residence of Decedent the Meryland 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Director Maryland Baltimore Catonsville 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? deeth with United States 21228 39 South Prospect Avenue Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 1 Yes 2 □ No WWII
If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelih marked other then "natural". A large any injury or other traumatic evens. 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Race Track Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Marie A. Moran Flecther T. Collins 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 39 S. Prospect Avenue Catonsville, MD 21228 Flecther T. Collins (Brother) 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park5/8/00 Elkridge, MD 21. Signature of Funerel Servica Lice 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the duality Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. 1328 Sulphur Spring Road Arbutus, MD 21227 Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final artinoma OF colon with metatasi disease or condition resulting in death) Examiner Physician/Medical Examiner neumonia attending physician and I for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760. Due to (or es a consequence of): signed by the a P.O. Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Records, by 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24e. Was en autopsy performed? pege 2 should Medical Certification: To Be Completed After this certificate hes 1 Yes 2 No 1- Yes 2 No of Vital septal or Attending Physician: The hours efter deeth.

nerel Director: After this certificate y filled in by the funerel director, pe 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Mennør of Deeth 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Neturei 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funerel Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 29c. License number Do019668. Rm. Shah my MAY 4, 2000 BON SECOUR Hospital Baltimore, 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

**DHMH 16 Rev 6/95** 

State Registrar

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

		Certificate of	Death	Reg. No.			
Dhysisian	1. Decedent's Name (First, Middle, Last)		2. Dete of Month	Death Dey Year	3. Time of Death		
Physician /Medical	GORDON		Cook Ma	u 5 2001	0 4:08		
Examiner	4a Facility Name (If not institution, give street and number)	11 261	4b. City, Town, or Location of D		ith		
	The Johns Hopkins	HOSP, 191	Baltimor				
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. In 1974) 1974 1975 1975 1975 1975 1975 1975 1975 1975	ast birthday) If Under 1 Year  Months Days	Hours Min. (Month)	Birth Year 1938 Ma	rthplece (State or Foreignuntry)		
Director	219 20 0017 11 02	118.	SEPI	25, 1930 Ma	ryland		
B 2	Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location			10d. Inside City Limi		
raho or		Circleville			1 ☐ Yes 2 ☑		
or 28a-fa	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?		
	402 Havenwood Court	43113	3	USA	,·		
errer dean with the Marylen or Neme 23e or 28e-1 show britter must be notified at / Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S	S. 13. Wes Decedent of h	lispanic Origin? (Specify Yes or	No- 14. Race - Am	erican Indian,		
Fur Fig.	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cubi	an, Mexican, Puerto Rican, etc.)	Black, Whi			
by by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☐ No	Specify:	Specify:	White		
The routs enter death with the marylend Theturel', or heme 23e or 28e-f ahow tolcal Exerciter must be notified at leted by Funeral Director	15. Decedent's Education	16a. Decedent's Usual Occup	pation	16b. Kind of Business	s/Industry		
T	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d) most of working				
giene.	5+	Mechanical	Engineer	Dupor	nt		
T & S	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mid	AND THE REAL PROPERTY.			
Mente merked	Frederick Charles Cook		Doris Keo	wn Hines			
and Men is merke aumatic	19a. Informant's Name/Relationship (Type, Print)		and Number or Rurel Route Nu				
125	Carol A. Cook/Wife		od Ct., Circ	leville, (	)h10 4311		
or other	ADDINA ON COMMENT OF THE COMMENT COMMENT	ece of Disposition (Neme of emetery, cremetory or other ple		20c. Location - City o			
7 # 6 #	4 Donation 5 Other (Specify) Me	tro Cremator	y, Inc. 5/8/00	Baltimo	re, MD		
Department Important: any injury	21. Signature of Funeral Service Licensee	22. Name and Addre	ess of Facility iety of	Maryland	Inc		
SESS	Edward A. regorchik		erick Rd. Ba				
44 1 1	23a. Part1. Enter the disease or complications that caused the death shock, or heart tellure. List only one cause on each line.				Approximete		
hysician	shock, or heart tellure. List only one cause on each line.				Interval Between Onset and Death		
Medical	Immediate Cause (Final	BRAIN HEEN	SIATIONS		15 im		
kaminer	1 resulting in death)	as a consequence of):	SAW		15 HRS		
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n end iel-transit Examlner	Sequentially list conditions  Due to (or	as a consequence of):	JAME 1910	or vec			
EX.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PANITADEN	1.A-		14,400		
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been sign should be	Huxer tension			Vas an autopsy erformed?	. Were autopsy finding available prior to		
s been 2 shoul pletec	Gigat Jucolot				completion of cause of deeth?		
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certificate rector, pag	25. Was case referred to medical		26. Place of Death (Check or	nly one)			
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er this certific eral director, n: To Be	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Inju		ibe how injury occurred			
leath. for: After the fune cation	1 Natural 5 Pending (Month, Dey Year) 2 Accident investigation		Yes 2□No				
after death. Director: After I in by the fune		me, farm, street, factory, offica	28f. Locatio	on (Street end Number or I Town, Stete)	Rural Route Number,		
as after death.  al Director: After tied in by the funera  Certification:	4 Homicide building, etc. (Specify,		Oily oi	rown, cialay			
hours y filled	29a. Certifier 12 Certifying Physician: To the best of my know						
within 24 hours after d To the Funeral Direct completely filled in by Medical Certifi	(Check only one)  Medical Examiner: On the basis of examinations and manner steled.	on and/or investigation, in my of	opinion, death occurred at the til	me, dete and place, and du	ue to the cause(s)		
within To the comple	29b. Signature and title of Sertifier	29c. Licens	se number	29d. Date signed (Mor	oth, Dey, Year)		
[0	* THE HARMOUR	Pr	7,000	lais or	, 2000		
YY	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)		1	· ·		
6	Her Thomas It	H GOD N.	WOLFE ST.	PAITTHM	E ND.		
State	31. Date filed (Month, Day, Year) 32. Registrar's Signat			1	,,		
Registrar	MAY 9 2000 Sener	& spa	4.				

DHMH 16 Rev 6/95

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\Omega\)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year CANNON **Physician** WILLIAM 10:05 PM APRIL 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE CENTER HOSPITAL Hours Min. 8. Date of Birth (Month, Day, Year) March 25 1935 Mary Land 5. Social Security Number 219-32-0109 If Under 1 Year 7. Age (In yrs. last birthday) 65 yrs Birthplace (Stete or Foreign
Country) **Funeral** Days 1 X M 2 □ F Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. n/a Baltimore 1 No 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1702 Belt Street 21230 TISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No Korean If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mantel Hygiena. Intropretant: if Nem 27 is marked other than "natural, or herr eny injury or other traumatic event, the Medical Examinations." 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 X No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Baltimore City 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Richard H. Cannon, Sr. Anna Mae Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9746 Conmar Road, Baltimore, Md. 21220 Richard H. Cannon (Brother) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 5/05/00 Green Mount Cemetery Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P, A. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part 1. Enter the disease, or complications that eased the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical AND PNEWMONITIS ASPIRATION Examiner Due to (or as a consequence of): Physician/Medical Examiner (30) DUE TO COMPLETE HEART sicien end buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien s the burie P.O. Box 68760. CORONARY ARTERY Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Pres 2 No 3 Probably 4 Unknown ped t Records, à 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy 1 Yes 2 No 1 Yes 2□ No Division of Vital To the Hospital or Attending Physician: "
within 24 hours after death.
To the Funeral Director: After this certifica completely filed in by the funeral director; p B 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Suppatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 Whatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P13/40 APRIL 30, 2000 MEDICAL RESIDENT ON CALL 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL, 3001 S. HANDVER ST, BALTIMORE MD 21225 BADE MD 31. Date filed (Month, Day, Year) State MAY 9 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** Monica 6:20pm ma 2000 /Medical 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Johns Sex 7. Age (In yrs. last birthday) if Under Cit 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Hours Devs 10 M 20 F 219-80-4538 37 Director MD 12-22-62 Usual Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Herns 23a or 28a-f show ith end Mental Hygiene. 27 is marked other than "natural", or frems 23a or 28a-f show trsumatic svent, the Medical Examiner must be notified at 1 Ves 2 □ No **Funeral Director** NA Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 1502 East 29th Street permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a and Injury or other traumatic avent, the Medical Examiner meats pages. 21218 USA 12. Was Decedant Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2X No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 Yes No Specify: À Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 12th grade College (1-4or 5+) NA Clerk Company 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George 2 Cates Barbara Clowde 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 21218 19a. Informent's Neme/Reletionship (Type, Print) Barbara 1502 E. 29th Street Baltimore, Maryland Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e Method of Disposition Dete 20c. Location - City or Town, Steta Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Zion Cemetery 05-10-2000 Lansdowne, MD 21. Signature of Funeral Service Liceosee 22. Name end Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23s. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) neomorna **Examiner** Metastases Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of): letastatic Box 68760. The law requires that the death certificate be Physician/Medical Cause (Disease or injuithat initiated events resulting in death) Last 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? š 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 88 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20140 To 1 Inpatient 2 ER/Outpatient 3 DOA Pils 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Affier Attending s Z Natural 5 Pending investigation 2 ☐ Accident 1 Yes 2 No after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide 6 within 24 hours To the Funeral Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier er: On the basis of exa 296. Sign. 29c. License number 29d. Date signed (Month, Day, Year) 2000 cause of death (Item 23a) (Type, Print) BACTIMORE, MANNETTE WOLFE ST.

**DHMH 16 Rev 6/95** 

State Registrar

31 Date filed (Mr.

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State of Maryland / Department of Health and Mental Hygiene \(\Omega\)

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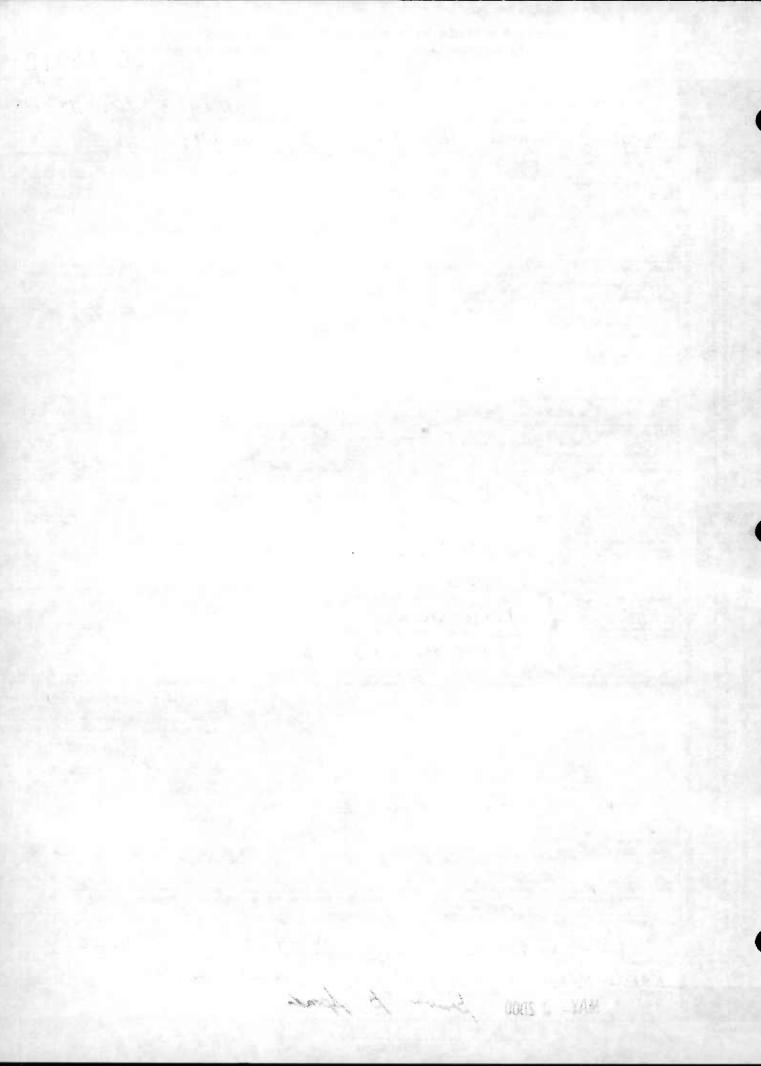
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Yeer Ma World . 2000 10:05 AM LARRY G. CUSHEY 4a Fscility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Baltimore Baltimore Hertiage Center of Dundalk If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Months Deys Hours Yrs. 199-30-8762 60 Aug 8, 1939 PA Usual Residence of Decedent 10a. Stete MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7232 Germanhill Road 21222 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 none car hauler automotive 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Joseph A. Cushey Ada B. Fleeger 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Todd Cushey/son 102 E. Red Oak Ct Saxenburg, PA 16054 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☒ Donetion 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee Director 22. Neme and Address of Fecility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shack, or hear feiture. List only one cause on each line. Approximete Intervat Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): that initieted events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 1 Yes 2 No 25. Wes cese referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined

nding physician and use as the bunal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for signed by the a peed page 2 certificate after death.

Director: After this certifica director, funeral completely filled in by 24 hours a Funeral D

Physician/Medical þ Completed

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

death with the Meryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Menylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examples traus be northed at Page.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

Be Certification: To

Medical

State Registrar

31. Dete filed (Month, Day, Year)

3 Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signeture 2000

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner steted. 29d. Dete signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

person who completed reuse of deeth Mann 230) Type April TTCHIE HIGHWAY MARYLAND BALTIMORE,

To the Vithin 2

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4814 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Tima of Death **Physician** 2:30/2 Robert M. Carney /Medical 4a Fecility Nema (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNE BALTIMORE If Under 24 Hrs. If Under 1 Yaar Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 2 F 218-36-6443 60 Yrs. Director 18, 1939 Washington D.C. Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. inside City Limits rel', or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yas XXNo Director MD Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with 6971 Pindell School Road 20759 U.S.A. Funerai 12. Wes Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 XX Yo If Yes, Giva Yaar or Datas: 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel Hygiena. Important: if Nem 27 is marked other than "naturel", or Nem any Injury or other traumatic event. Bleck, White, etc. 1 Never Merriad 2 Warried 1 Yas 2570 Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Certified Public Accountant self-employed 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Robert M. Carney Helen Anderson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Wife 6971 Pindell School Road Fulton, Maryland 20759 Carney 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cramation 3 ☐ Removal from Stata 5-9-00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Washington Crem. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Witzke Funeral Home, Inc. 21228 1630 Edmondson Avenue Catsonville, Maryland 23a. Pertyl Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one obuse on each line. Approximata Intarval Between Onsat and Death **Physician** immediata Causa (Final diseesa or condition rasulting in death) Non Small Cell Lung Co /Medical 8 months Examiner Physician/Medical Examiner use as the burial-transit Sequentially list conditions, if any, leeding to immadiate causa. Entar Undarlying Cause (Disease or injury and Dua to (or as a consequanca of): that initiated evants rasulting in death) Last Dua to (or es a conseguança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Š 24b. Wara eutopsy findings aveilable prior to completion of ceuse of death? Be Completed 24a. Was an autopsy performed? or Attending Physician: 25. Was casa referred to medical 26. Placa of Death (Check only ona) examiner? 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) Medical Certification: To 1 Appatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred After Natural 5 Panding after death. 2 Accident 1 Yes 2 No invastigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida hours : Funerel Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data end place, end dua to tha causa(s) and mannar as statad.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifia: within 2 29b. Signetura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

31. Data filed (Month, Day, Year)

30. Name and addless of

Ave Baltimore MI) 21229

**DHMH 16 Rev 6/95** 

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

a	mend item	16	oa per fh G783 5/17/0	00 vg	iai yiai		tificate o	f Death		leg. No.	14816				
	Physiciar		1. Decedent'a Nama (First, Middle, Last)  Catherine Louise Cahn							Day Y	3. Tima of Death				
	/Medica	_	de Feditiv News (Mass institution che street and support							7 20 4c. County of					
74	Examine		Subacute Care at Southern Maryland Hospital Clinto								George's				
	Funeral Director		5. Social Security Number 214-44-1819			last birthday) 54 Yrs.			8. Date of Birth (Month, Day July 2)		B. Birthpleca (Stata or Foraign Country) Maryland				
	puel Maria	-	Usual Residence of Decedent  10a. Stata 10b. County		10c. C	ity, Town or Lo	cation				10d. Insida City Limits				
	death with the Maryland irre 23a or 28a-f ahow ir must be notified at	2	Md. Prince	George's	Ur	per Ma	rlboro				1 ☐ Yas 2 🛣 No				
	or 28		10e. Street and Number		1 -1		10f. Zip Code			10g. Citizen of Wh	at Country?				
	ath w		14905 Mount Calv				207			U.S.A					
21215-0020	of, or he	Dy ru	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 1 1 Yes, Giva Year or Dates:	?		□Yes 2X N			14. Raca - Black, Specify:	Amarican Indian, White, etc. White				
5-0	nature",	016	15. Decedent's (Specify only highest	Education		16a. Deced	ent'a Usual Occ	upation e during most of work red) Personnel	kina	16b. Kind of Busin					
121	within ans.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Paras	O NOT use reti	Personnel		Presider					
	Hygied H	3	17. Fathar's Name (First, Middla, La	st)		l lers	<del>ona i</del> co	nsultant	a (First Middle	Maiden Sumama)	soc. Inc.				
an	Mental H Mental H arked oth			gler				Anna	Wasyl						
0	should ind Men inmerke umerke		19a. tnformant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Stre	et and Number or Ru		r, City or Town, St	tata, Zip Coda)				
-	and 2 paith a 27 le		David L. Cahn (	Husband )		14905	Mount	Calvert Ro	ad Upper	Marlbon	o, Md.20772				
Baitimore	or oth	1	20a. Method of Disposition  1 Denial 2 Cremation 3	☐Bernoval from State		Place of Dispo- cemetery, cren	sition (Name of natory or other p	lace)	Date	20c. Location - Ci					
tim	trant tant: Jury		4 Donation 5 Othar (Spe	cify)		Cedar H	ill Cem	etery 5	/11/00		re, Maryland				
Bai	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglana. Important: If Item 27 is marked other than ery injury or other traumed's event, the Mappe.		21. Signature of Funeral Service Lie	Allin		23	7 E. Pa	lress of Facility Olyniak Fu tapsco Ave	nue Bal	timore, N	Maryland 21225				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List or immediata Cause (Finat disease or condition resulting in death)					ying, such as cardiac		ast,	Approximata Interval Batween Onsat and Daath PPROX 5 minutes				
			in and any	C .=		or as a conseq	uence of):				MORE THAN				
	exacuted in end riel-transit		Continue No. No. and Alexander	b. 5E	PSI	or as a conseq	uonno off-				2 WEEKS				
o,	tificate be executed g physician and es the burlet-transit	LY	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	DN		MON.					MORETHAN 2 WEEKS				
68760,	licate be physicia s tha bu	2	Cause (Disease or Injury that initiated events rasulting in death) Last	c		or as a consequ					a weeks				
	ling p	- 1		MET	AS	1TAT	C	LUNG	CANO	1=12					
Вох	attendin for use	180		0				- 0( ) 0							
P.0.	at the deeth cert of the attendin etached for use	1	Part It. Other significant conditions	contributing to death I	but not res	sulting in the ur	derlying cause	given in Part I.			ibuts to the cause of death?				
0	igned by De deta		DIABET	Es m	ELL	STUS	3	121	102(1	'ss 2□No 3	B Probably 4 Unknown				
of Vital Records,	been s should	חופופת ה							24a. Was a perfor		24b. Wara autopsy findings availabla prior to completion of cause of death?				
B	ician: The lay cartificate has rector, page 2	5							1 U Y	as 2×No	1 ☐ Yas 2 No				
/Ita	slan: artiflor octor,	3	25. Was case refarred to medical examiner?					26. Place of Dee	th (Check only o	na)	eu Ranuss-				
Ion of \	1 8 8 4 E	2	2	2	2	2	1   Yas 2   No  27. Manner of Death 1   Senatural 5   Pending 2   Accident investigat	Hospital: 1 Inpati		28b. Time of Injury	28c. In		loma 5 Rasidence 6 Othar (Specify) SUBHCUT 28d. Describe how injury occurred 5.771-H		
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funaral Macdical Certification:		3 Suicide 6 Could not determine	28e. Place of In building, e	ijury - At h tc. (Speci	oma, farm, stri	et, factory, offic	0	28f. Location (5 City or Tow	treet and Number n, Stata)	or Rural Routa Number,				
	he Hospit in 24 hour he Funera plately filli		29a. Cartifier (Check only one)	Physician: To the best aminer: On the basis of and manner s	of examina	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place, opinion, death occur	and due to the cred at the time, c	ause(s) and menr late and placa, an	ner as statad. d dua to tha causa(s)				
	Within To the comp		29b. Signature and title of certifier		^		29c. Lice	nse number		29d. Date signed (	(Month, Day, Year)				
	0		Lego	mchd	N	nama	, I	5065	53	5 - 7	-2000				
	(	1	30. Nama and address of person wh				Print) G	YAN CH	AND	SURAI	-2000 VA 20751				
				E CHUX		1,000	ROAL	DEF	ILE . I	nD. 8	20751				
	State Registrar		31. Data filed (Month, Day, Year)	2000 32. Regist	rars Sign	ature	Spo	reks							

DHMH 16 Rev 6/95

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death **Physician** Marjorie Caldwell Maxine 9:00 2000 May /Medical 4b. City, Town, or Location of Death 4e Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) July 7, 1929 6 Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XLE Months Days Hours 219-20-4658 70 Yrs. MD Director Usuel Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ahow 10 Yas 2 □ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rema 23a 102 Washington Street 21750 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva 14 Baca - Amarican Indian 11. Merital Status Black, Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 6 1 Yes 2 No Specify: Be Completed by Specify: 3 ☐ Widowad 4 ☐ Divorcad White 'natural' 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada complated) l Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) Presser Clothing Manufacture permit. Peges 1 and 2 should be filed w Department of Health and Mentel Hygiel Important: if item 27 is marked other th any injury or other traumatic avent, the 8 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Edward Caldwell Lula Broadwater 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lois B. Caldwell/Sister 102 Washington Street Hancock, MD 21750 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Warfordsburg Presbyterian 5/4/00 Warfordsburg, PA 21/Signature of Funeral Services 22. Nama and Address of Facility Grove Funeral Home, P.A. 141 W.Main St. Hancock, MD 21750-0368 Approximete Interval Between Onset end Deeth 23a. Pert1. Entar the disease, or complement that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one selese on each line. **Physician** immediata Causa (Final disease or condition resulting in daath) /Medical Examiner Due to (or es a consequence of) Physician/Medical Examiner di sease e rena The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Records, P.O. Box 68760, nephropathi Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes ZO No 3 Probably 4 Unknown peritaniti's pege 2 should be 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed 24a. Wes an autopsy 20 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas certificate Division of Vital or Attanding Physician: 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 30 No Inpatient edical Certification: To 1 Yas 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Day Year) 27. Mannar of Daath 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? 5 Panding Investigation 1 DNatural efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicida To the Hospital of within 24 hours of To the Funeral D Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mennar as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Cartifiar completely (Check only one) 29b. Signetura end titla of certifiar 29c. License number 29d. Data signed (Month, Dey, Year) By 611182 30. Neme and address of person who complated causa of daeth (Item 23a) (Type, Print)

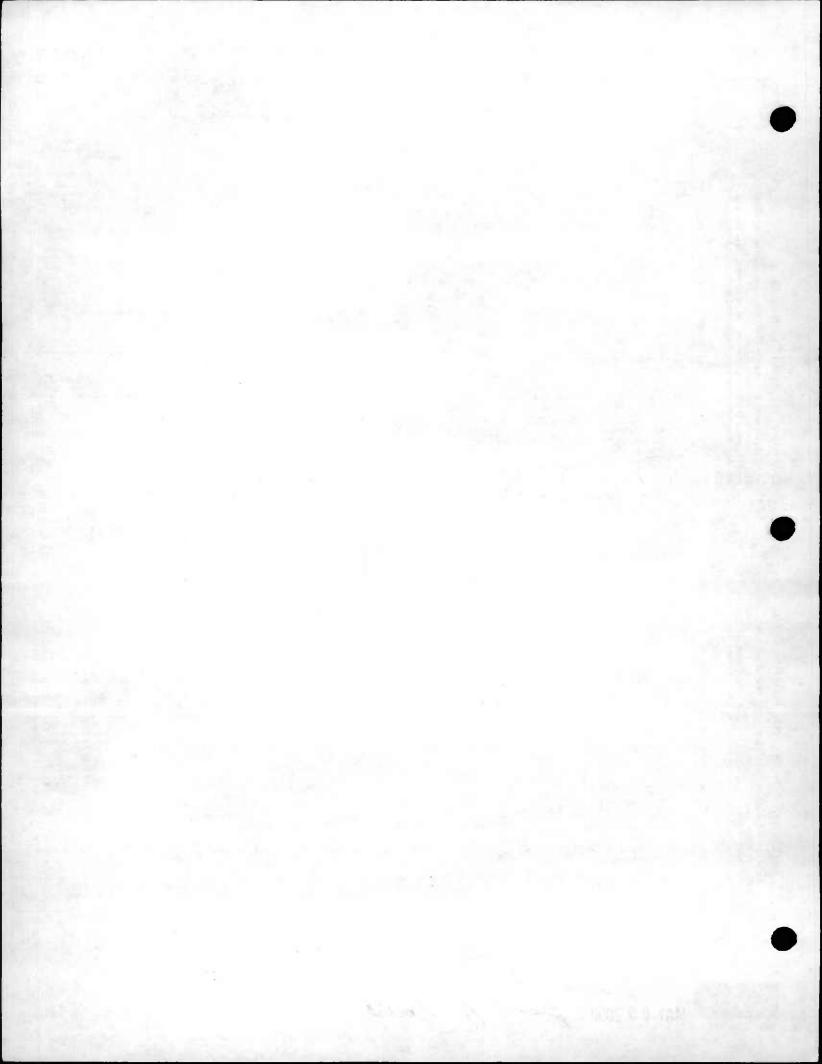
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Dey, Year)

ORIGINAL

Yan Ping Yu, M.D. 12931 Oak Hill Avenue Hagerstown, MD 21740

32. Registrer's Signature



# Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Cancila	item 23a per phys. G78.  1. Decedent's Name (First, Middle, La		Certific	410 01 1		2. Date of De	Reg. No.	3. Time of Death				
Physician /Medical	Fanya 4a Facility Name (If not institution, giv		ECHI	K,	lb. City, Town, or I	April  ocation of Deeth		Year 2000 0940 of Death :				
Examiner Funeral	Sinai Hospin	tal of Bal		nder 1 Year	Balt If Under 24 Hrs.	imore		9. Birthplaca (State or Foreign				
Director	217-19-8881 Usual Residence of Decedent	1□ M 2 F 90	Yrs. Mont	hs Days	Hours Min.	8. Date of Bir	1910	BELORUSSIA				
anyland thow	10a. Stete 10b. County		ity, Town or Location					10d. Inside City Limits				
ith the Merylar or 28a-f show a norther a	MD N/A	BA	ALTIMORE					Yes 2□No				
23a za	10e. Street and Number 3601 FORDS LANE A	PT. 815		Zip Code 212]			10g. Citizen of V USA					
5 2 5	11. Meritel Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s 2 No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		a - American Indian, ck, White, etc. WHITE				
ete ore	15. Decedent's E (Specify only highest gra	ducation ade com <i>pleted)</i>	16a. Decedent's U	Jsual Occup work done	ation during most of wor f)	king	16b. Kind of Bu	usiness/Industry				
be filed within 72 ho tel Hygiene. d other than "nature event, tre Medical Be Completed	Elementery/Secondary (0-12)	College (1-4or 5+)	HOMEM		"	10	OWN HON	ME				
filed with Hygiene. other than	17. Father's Name (First, Middle, Last	)			18. Mother's Nan	ne (First, Middle,						
Mentel I	JOSEF	KUNDA			ROSA		(UNO	BTAINABLE)				
d 2 sh th end 7 ls m treum	19a. Informent's Name/Relationship ( EUGENE CHECHIK/ S	• • • • • • • • • • • • • • • • • • • •	19b. Mailing Addr 3822 HUD	ress (Street SON S'	and Number or Au TREET BAI	TO. MD.	er, City or Town, 21224	State, Zip Code)				
THE THE	20a. Method of Disposition  1X Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	Place of Disposition ( cemetery, crematory)	or other place	(e)	Date 5/2/2000		City or Town, State				
pemit. Peg Depertment Important: I eny Injury o	21. Signature of Funeral State Lice	The same of the sa			ss of Fecility SOL	LEVINSC	N & BRO	S. INC.				
	23a. Pert1. Enter the disc se, or com shock, or heart failur. List only	Mcations that caused the dea	ith. Do not enter the r	REIST.	ERSTOWN I	or respiratory a	rest,	, MD. 21208 Approximate				
Physician	shock, or heart failure. List only	one ceuse on each line.						Interval Between Onset and Death				
/Medical	Immediate Cause (Final disease or condition	AS	Divation	TE	RMINAL ASPI	TRATION		20 min				
Examiner	disease or condition resulting in death)  Due to (or as a consequence of):											
executed on and iel-transit												
secut and si-trar												
ificate be executed graysicien and es the buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as e consequence of):											
Se es	resulting in death) Last	d	or as a consequence	O1).								
net the death cert d by the attendin letached for use	Part II. Other significant conditions of	contributing to death but not re	culting in the underlying	na cauca ais	en in Part I	23h Did	tobacco usa co	ntributa to the causa of death'				
	Atrial fibrill	3 ☐ Probably 4 ☐ Unknow										
The lew requires that the death cercate has been signed by the attendir pege 2 should be detached for use Completed by Physician/R	disease		ular	24a. Was	24b. Were autopsy findings available prior to completion of cause of death?							
The lew cate hes pege 2	1 □ Yes 2 □ No							1 ☐ Yes 2 No				
ysician: The is certificate director, peg	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea		anne de la la la la la la la la la la la la la					
ng Phys Mer this uneral di	1 Yes 2 No  27. Manner of Death 1 Matural 5 Pending investigation	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 LI Nursing r		dence 6 Oth	* * * * * * * * * * * * * * * * * * * *				
To the Hospital or Attending P within 24 hours after deeth. To the Funerel Director: After the completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)  28e. Placa of Injury - At home, ferm, street, factory, office City or Town, State)											
To the Hospital or At within 24 hours after of To the Funseal Direct completely filled in by Medical Certifi		lysician: To the best of my kninner: On the basis of examinand manner stated.										
Withir Comp	29b. Signature and title of certifier	4.	0	29c. Licens		11 10	29d. Date signe	d (Month, Dey, Year)				
	2 de	AM)	Kesident	RE	500c		Apri	1 30, 2000				
	30. Name and address of person who	npleted cause of death (Ite	m 23a) (Type, Print)				11					
	CAMMARI	ana Mis										

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\cap \) 14819 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death May 9, 2000 1:00 A.M. Nellie Agnes Dilmuth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Glen Burnie Glen Burnie If Under 24 Hrs. 8. De Hours Min. Anne Arundel If Under 1 Yaer 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 200 F Days Months 218-07-8592 Yrs. Maryland May 4, 1921 Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tas 2 No Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2031 5th Avenue 21225 U.S.A. 12. Wes Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 0 No If Yas, Give Yeer or Dates: Was Decedent of Hispantc Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indien, Black, Whita, atc. 11. Maritel Status 1 Navar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Polan & Katz Elamantary/Secondary (0-12) Collega (1-4or 5+) 8th Seamstress Umbrella Company 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Henry Frederick Wenger Bertha E. McKenny 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Seward Avenue Baltimore, Maryland 21225 Mary E. Harrison ( Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremetion 3 Removal from Stata Cedar Hill Cemetery 5/12/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee McCully-Polyniak Funeral Home, P.A. 23a. Pert1. Enter the disaesa, or complications het causad the death. Do not enter the mode of dying, such es cerdiac or raspiratory errest, shock, or heart failure. List only one cause on each line. 237 E. Patapsco Avenue Baltimore, Maryland 21225 Approximata Intervel Between Onsat and Death ASPIRATION PNEUMONIA

LEFT HOMIPLEGIA BUE TO RICVA. Immediata Cause (Final disaasa or condition rasulting In death) Sequantially list conditions, if any, laading to immediata ceusa. Enter Undarfying Cause (Disaase or injury that initieted evants rasulting in death) Last Due to (or es e consequence of): DIABEFES -2 AND HYPERTENSION Dua to (or es e consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? GASTINESUPHAGEAL REFLUX. 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA. BLADDER 24b. Ware autopsy findings available prior to complation of cause of daath? 24a. Was an autopsy parformed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was casa raferred to medicel axaminar? 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accidant

/Medical Examiner Physician/Medical Examiner physician end is the buriel-transit thet the deeth certificata be executed P.O. Box 68760, Records, Completed by or Attending Physician: The law requires Division of Vital Be Medical Certification: To this Hospital or Attending 1.24 hours after death.
 Funeral Director: After lately filled in by the fur

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ref, or frems 23a or 28a-f ahow Examiner must be notified at

\*naturel', or

permit. Pages 1 end 2 should be filed within 72 hx. Department of Health and Mental Pyglene. Important: if Item 27 le marked other than "naturany Injury or other treumatic event, the Medical Page.

**Physician** 

72 hours efter

Baltimore, Maryland 21215-0020

Director

Funeral

Completed

2

To the Hosp within 24 hor To the Fune complately fi State Registrar

29b. Signatura and titla of cortical 30. Nama and addrass of parson who complated cousa of death (Itam 23a) (Type, Print) CHURCH SF. BALTYMORE, M921225

29a. Cartifiar

3 Suicide

4 Homicide

(Check only one)

31. Data filed (Month, Pay, Year)

6 Could not be datarmined

9 2000

32. Registrar's Signatura

makes, Mss.

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To tha best of my knowladga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

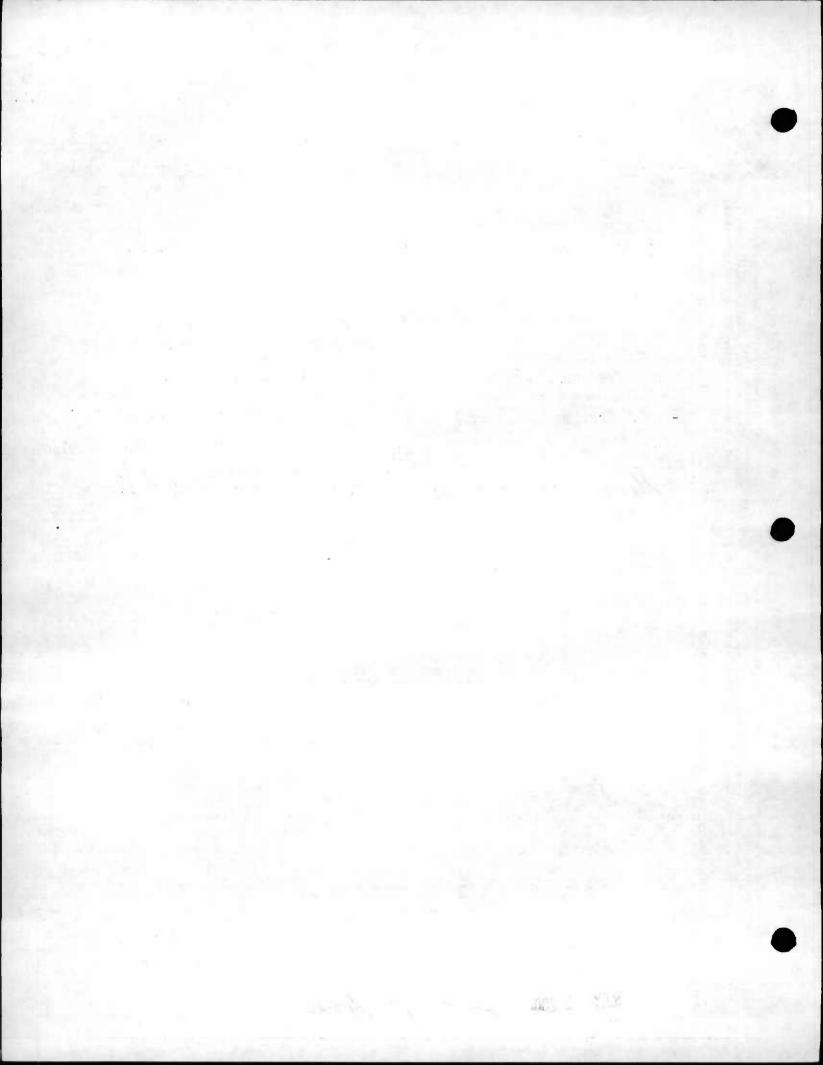
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and mannar stated.

29c. License number

D17753

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)



### Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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14820

				Cer	tificate c	or Deatr	7		Reg. No.		
hysician	1. Decedent's Neme (First, Middle,							2. Dete of Do Month	Dey	Year	3. Time of Death
/Medical	William James Ross Dunseath  May 6 200  4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deeth 4c. County of De									9:00 PM	
xaminer	4a Facility Neme (If not institution, give street end number) 4b. City, Town 107 Enfield Road Baltin						•		N/A	4c. County of Deeth	
neral			. Age (In yrs. las	t birthdey)	If Under 1 Ye	ar If Unde		8. Data of Bi (Month, D	-	9. Birthpla	ice (Stete or Forai
ector	143-16-9911	. Sex 7 1 M 2 □ F	77	Yrs.	Months De	ys Hours	Min.	April	13 1923	New .	Jersey
	Usuel Residence of Decedent  10a. Stete 10b. County		10. 00.								414-14-05-11-1
uneral Director				Fown or Lo						10	d. Inside City Limi 1 ☑ Yes 2 ☐ N
ctc	Maryland N/A		Balt	imore					10g. Citizen of \	***	
ត់	107 Enfield Road	1			10f. Zip Cod				United		,
Funeral Director	11. Maritel Status		dent Ever In U.S.	13. \			rlain? (Spec	cify Yes or No		e - America	
FC	1 Never Merried 2 Married	Armed Ford	ces? 2 □ No		Ves Decedent of Yes, specify C			Rican, etc.)	Bled	ck, White, et	
	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Year or Det		1	I□Yes 2∭ I	No Specify	<i>'</i> :		Specify	· Whi	Lte
To Be Completed by	15. Decedent's (Specify only highest)	Education		16a. Deced	lent's Usual Oc	cupation	et of workin	na	16b. Kind of B	usiness/Indu	istry
npie	Elementery/Secondary (0-12)	College (1-	4or 5+)		kind of work do OO NOT use re	tired)	St Of WORKIN	'9			
Co		5+		Physi	.cian				Medica		
Be	17. Fathar's Name (First, Middle, La		- 41-						, Maiden Sumerr		
P			seath						lia Spie		
	19a. Informant's Neme/Reletionship Suzanne Dunseat		fo)		Enfield				per, City or Town, Marylar		
	20e. Method of Disposition	.1 (WI	20b. Pled	e of Dispo	sition (Nama of	r	Dari	Dete ,	20c. Location		
	1 Ŋ Burial 2 ☐ Cremetion 3		Tate		s Cemet		5/	10/00			
	4 Donetion 5 Other (Spe		ot.					10/00	Daltin	ore, r	Maryland
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc.										
	23a. Pent 1. Enter the diseesa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line.										
н	shock, or haart feilure. List or								nrest,		Approximate nterval Between Onset and Death
	Immediate Cause (Final	100	TE M	1Vac	LADAL	TAIRA	1ctio	-/			di dimes
	diseese or condition resulting in death)	o. 1+CU	IE "	(700)	MENTIL_	LIVITIA	-0119	-			1111110103
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at io	1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investiget		, Day Year)	Injury		Work? I∐Yes 2∐	] No				
Iffice	3 Suicide 6 □ Could not	3 Suicide 6 Could not be 28a. Place of Injury - At home fa					2	28f. Location	(Street and Numi	per or Rurel	Routa Number,
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cai	29a. Certifier 1 Certifying (Check only 2 Medicat Ex	Physician: To the b	est of my knowle	dga, daeth	occurred at th	e time, date e	nd plece, e	end due to the	ceuse(s) end m	annar as sta	itad.
edicai	one)	aminer: On the bas and manne	er stated.	n end/or inv	restigation, in n	ny opinion, de	eth occurre	ed et the time	, data and place,	and dua to	ina cause(s)
Σ	29b. Signature and little of certifier	10	11		_	PACC-	, 7		29d. Data signe		ley, Year)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 18:30 PAMEL DORSEY 5 04 /Medical 4a Facility Name (If not Institution, give street and number), 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mary lance 1314 NStems -mone N/A If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 TF 53 Director 26, 1946 220-76-2449 Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD Anne Arundal Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7136 Forest Avenue 21276 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Spacify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☑ No Specify. Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Louis Wilson Dorsey Lilian A. Galla 19a. Informent's Name/Reletionship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7136 Forest Avenue Hanover, Maryland 21076 Lilian Dorsey mother 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Date 1X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vermillion Chapel 5-9-00 Elkridge, Maryland 21. Signeture of Funeral Service Licanses 22. Name and Address of Facility Gary L. Kaufman F.H. Meadowridge Memorial Park m01050 7250 Washington Boulevard Elkridge, Maryland21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical CARDIOGENIC SHOCK MULTIPLE ORGAN FAILURE Examiner Due to (or as a consequence of) Physician/Medical Examiner CARDIAC ARREST The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last been signed by the attending physicien and should be datached for use es the burial-tran Due to (or es a consequenca of): Box 68760. Due to (or as a consequenca ot): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BACTEREMIA Division of Vital Records. þ To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director, After this certificate hes been signormpiately filled in by the funeral director, page 2 should I 24b. Were eutopsy tindings availeble prior to completion of cause of death? 24a. Was en eutopsy performed? Be Completed PNEUMONIA 2 X No 1 ☐ Yes 2 ☐ No 1 Tyes I or Attending Physician: after death. 25. Wes case reterred to medical 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 (Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homleide 29a Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.

| Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated.

| Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of certities AU417-6935 B959 00 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) PERCY BOATEHE DEPT. OF GENERAL SOUTH GREENE ST. BALTIMORE MA BURGERY 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar

MAY 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** IRENE W. EWING 6.45 P., 2000 4c. County of Deeth /Medical 4b. City, Town, or Location of Deeth 4e. Fecility Neme (If not institution, give street end number) Examiner Reisterstown Baltimore Cherry wood Manor Nursing Home If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral**  Birthplece (Stete or Foreign Country) 1□M 2√2 F Months Deys Hours Yrs. Director 101 180-12-1817 24, 1898 Balto. Peges 1 end 2 should be filled within 72 hours efter death with the Marylend nent of Health end Mental Hygiene. Int: If Item 27 is marked other than "nature!", or heme 23s or 28s-f ahow ary or other traumetic event, I'm Medical Evanmer natal be notified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Md. Baltimore Owings Mills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20 Milgate Road 21117 Funeral USA Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16e. Decadent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be 2 Michael Kilchenstein Helen Christopher 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Grundinsky 20 Milgate Road Joan Owings Mills, Md. 21117 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete permit. Peges 1 Department of H Important: If Ite any Injury or ot once. 1 ☼ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Forrest Hills Cemetery 4 Donetion 5 Other (Specify) 5/10/2000 Huntington Valley Pa 21. Signature of Funerel Servica Licanses 22. Name end Address of Fecility 11824 Reisterstown Road ELINE FUNERAL HOME ans enc Reisterstown, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respinock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Ceuse (Finel 6 months disease or condition resulting in deeth) Examiner Examiner ettending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequenca of) Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. this certificate has been signed by the ral director, page 2 should be deteched 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 1 Yes 2 12 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1 ☐ Yes 2 ☑ No 28e. Dete of Injury (Month, Dey Year) Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 Neturel 5 Pending efter death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. To the I within 2 To the I complet 29b. Signetun end title of certifier 29c. License number 29d. Date signed (Manth, Dey, Year) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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31. Dete filed (Month, Day, Year)

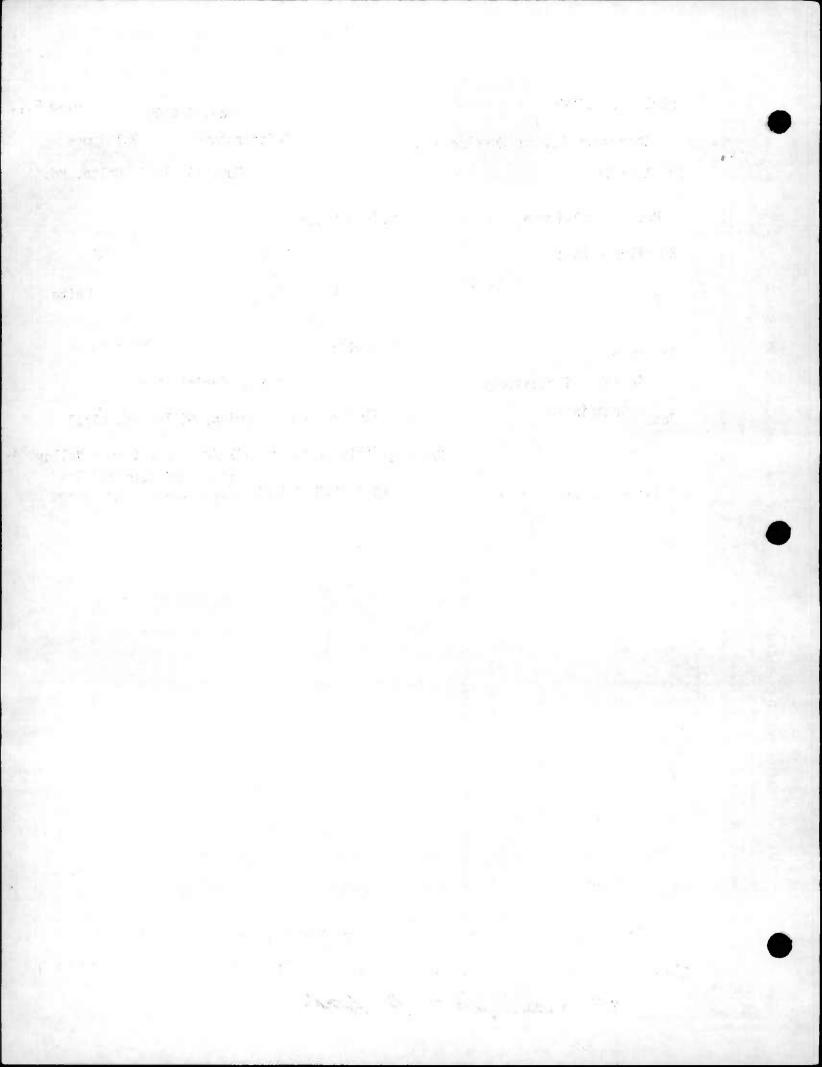
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32. Registrer's Signeture

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2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend item 25 per phys. G783 5/9/00 yg Certificate of Death

7. Aga (In yrs. last birthday)

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Yrs

10c. City. Town or Location

Salisbury

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1	4823
	3. Time of Death
ď	11:15 AM
eth	

Birthplece (State or Foreign Country)

MD

1 ☐ Yes 2 ☑ No

10d. Inside City Limits

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 22, 2000 Month MARY FRAILER APRIL 4e Facility Neme (If not institution, giva street end number) 4b. City. Town, or Location of Deeth 4c. County of De SALISBURY, MD. SALISBURY CENTER: GENESIS ELDERCARE WICOMICO

If Under 1 Year

10f. Zip Code

Deys

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Dey, Year)

1929

10g. Citizen of Whet Country?

Nov 20.

**Funeral** Director 5. Social Security Number 213-26-5679

10a State

MD

10e. Street and Number

Usuel Residence of Decedent

10b. County

Wicomico

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haaith and Mentai Hyglena. Infortant: If them 27 is marked other than "natural", or them any injury or other traumatic event, the pages.

Saltimore. Maryland 21215-0020

P.O. Box 68760,

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attanding physician and for usa as tha burial-transit signed by tha sid be detached paga 2 should peed cartificata has director. this funarai Aftar death.

The law requires that the death cartificate be executed Attending Physician: To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A complataly filled in by tha fu

Director 200 Civic Ave 21804 USA Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mentel Status 14. Race - American Indien. Black, White, etc. 14 Never Merried 2 Married 1 Yes 2 No Specify: white Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) +5 Elementery/Secondary (0-12) counselor education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Frank L. Frailer May Louise Dwyer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Genesis Eldercare 200 Civic Ave Salisbury, MD 21804 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Konald S. Wade 22. Nama and Addrass of Facility
State Anatomy Board Director 655 W. Baltimore Street Baltimore, MD 21201 or completed. In caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, and only one cause on each line. 23a. Part1. Enter the diseas sheck, or heart failure. Approximete Intervel Between Onset and Death fmmediete Ceuse (Finel disaase or condition resulting in death) Due to (or es e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leeding to immadiate cause. Entar Undarlying Cause (Diseese or injury that initieted avants resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy 1 Yes 2 2 NO 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2€ No 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 ANaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Streat end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 21804 William H. Robins, M.D. 1104 HEALTHWAY DR., SALISBURY, MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

MAY

2000

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** 15A.11 MARK 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 06 2000 /Medical 4c. County of Death Examiner BON SECOUR HOSPITAL BALTIMORE N/A 6. Sex 1 2 M 2 □ F 5. Sociel Security Number If Under 1 Year 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 41 Yrs. 216-52-2788 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Yes 2∏No BALTIMORE N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2812 WINCHESTER ST. 21216 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pagas 1 end 2 should be filed within 72 hours affer. Department of Haalth and Mantal Hygiene. Important: If Item 27 is merked other than "natural", or item eny Injury or other traumatic event. 1 Never Married 2 Merried 1□ Yes 2 No Specify: BLACK Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -12-DISABILITY N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be WILLIAM A. FOY JR. DOROTHY PAGE 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) WILLIAM A. FOY JR (FATHER) 2812 WINCHESTER ST. BALTIMORE, MARYLAND 21216 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial ☐ Cremetion 3 ☐ Removal from State 4 ☐ Dongston 5 ☐ Other (Specify) ENTOMBMENT ARBUTUS MEMORIAL PARK 5-11-2000 BALTIMORE, MARYLAND 22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Int1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, mock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 12herus disease or condition resulting in death) Examiner physician and is the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ 99 24b. Were eutopsy findings available prior to Completed 24a. Was en eutopsy completion of cause of deeth? 401 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 N Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dippetient 2 ☐ ER/Outpetient 3 ☐ DOA 2 27. Manner of Death Certification: Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

1 ☐ Yes 2 ☐ No

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated.

29c. License number 4420 29d. Date signed (Month, Dey, Yeer)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

no completed ceuse of death (Item 23a) (Type, Print)

32. Registrer's Signature

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

The law requires that the death certificate be axecuted P.O. Box 68760. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funerel Director: Aftar this certifica completaly filled in by the funaral director, I

ettanding p

Aftar this certificate has

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

investigation

6 Could not be determined

Baltimore, Maryland 21215-0020

Registrar

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State of Maryland / Department of Health and Mental Hygiene 14825 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 2000 Anne Roberts Fenwick 7:55 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) March 30 1902 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□M 2X F Days Hours 98 Yrs. 217-12-7194 Director North Carolina Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Funeral Director Maryland Baltimore Parkville notifie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? pernit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hydiene. Important: if from 27 is marked other than "naturel", or from a 23a or eny injury or other treumatic avent, the Medical Examiner meat be nonce. 8800 Walther Blvd. 21234 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ሺ No ff Yes, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Be Completed by 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Comptometer Operator Railroad 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Samuel Mason Roberts Margaret Anderson 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John B. O'Neill (Nephew) 348 Barnes Avenue Westminster, Maryland 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 5/9/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Road Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediate Cause (Finet diseasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner monary The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Couse (Disease or injury that included sease or injury Dua to (or as a consequence of P.O. Box 68760, that initiated events rasulting in death) Last Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Atrial fibrillation 1 Yes 2 No 3 Probably 4 Onknown Records, 2 page 2 should be 24b. Were eutopsy tindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? this certificate has 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Lei or Attending Physician: The state death.

In Director: After this certificated in by the funeral director, pa 25. Was case retarred to medicat 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 5 Pending 1 Netural 1 ☐ Yas 2 ☐ No 2□ Accident investigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledga, death occurred et tha tima, data and plece, end dua to the causa(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, date end plece, and due to the ceusa(s) and manner stated. 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Parkville, Md 21234 32. Registrar's Signatura State Registrar

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		State of	f Maryland		rtment of F		nd Mental Hy	/giene () (	0 14826			
Physician /Medical	Decedent's Nama (First, Midd	3.64 - 13.6	M. Free	edman			2. Data of D Month May	Day	3. Tima ol Death 2000 12:30 A.M.			
Examiner	4a Facility Name (If not institution, giva street and number)  4b. City, Town, or Lo  Mariner Health of North Arundel  Glen Bur							on of Death 4c. County of Death				
Funeral	5. Social Security Number		7. Age (In yrs. las	-	If Under 1 Year	If Under 24	Burnie Hrs. 8. Data of B					
Director	219 10 5112	1□M 2XIF	92	Yrs.	Months Days	Hours	Min. (Month, D		Birthplaca (Stata or Foraign Country)     Maryland			
Par III	Usuat Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location								10d. Inside City Limits			
r 28a-f show notified at	Maryland Anne Arundel Baltimore							1 ☐ Yes 2√∑ No				
or 28a-fe be notifies Directo	10e. Street and Number	_			10f. Zip Code	_		10g. Citizan of What Country?				
her death v r Items 23s siner must Funeral	103 Haile Ave		edent Ever in U.S.	13 V	2122		1? (Specify Yas or N	U.S	e - Amarican Indian,			
by Ext.	1 Never Married 2 Mai	Tied Armed For	rces? 200 No	- 11	Yas, specify Cuba	an, Mexican, 1 Specify:	Puarto Rican, atc.)		ck, Whita, atc.			
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and and and and and and and and and and	19a. Informant's Name/Relation				•		or Rural Routa Numi					
2 T 24 to	Charlotte Elliott / Daughter 8 Mohawk Avenue Glen Burnie, Maryland 21061											
Rimore, It. Pages 1 ar utment of Hea rdant: If hens njury or other	20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c.											
Balti pemit. I Departm Importer any inju	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Conce Funeral Home P.A.  4001 Ritchie Highway Baltimore, Md. 21225											
	23a. Part 1. Enter the disease, of shock, or heart feilure, List	r complications that cr	aused the death.						Approximate Interval Batween			
Physician /Medical		_							Onset and Death			
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Conflictive Heart Four Willed								Mont.			
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/60, te be executed seleten and se burial-transit cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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20 8 8 5	Dua to (or as a consequence of):  Chronic Brown Sy							mobrane 10+0				
death death death ed for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did	23b. Did tobacco use contribute to the cause of death?				
IS, P.O. BOX to as that the death certification by the attending be deteched for use as by Physician/Me	glancoma.						_ 10	1 Yes 2 No 3 Probably 4 Unknown				
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Page P							10	Yas 2 No	1 Yas 2 No			
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VISION OT VITE Attending Physician: r deeth. actor: After this certific by the funeral director. Mication: To Be	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii	28a. Data o		Bb. Tima of Injury	28c. Injur	4 IXI Nurs		idence 8 DOth				
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Hospi 24 hou Funer tely fill	29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the S Examiner: On the ba and mann	sis of axamination	odge, death n and/or inv	occurred et the tir estigation, in my o	me, data and p pinion, death	place, and due to the occurred et the time	a ceusa(s) end ma , date end plece,	annar es stated. end due to the ceuse(s)			
To the within 2 To the comple	29b. Signature and title of certifie	0	2 (		29c. Licens	e number 4/3 t	5	29d. Date signer 5/8/	d (Month, Day, Year)			
1819	30. Nama and eddress of person Gillu Bu	who completed cause	e of death (Item 2)	3a) (Type, 1	Print) Suit	e 201	Crain	Tower	2			
State Registrar	31. Data filed (Month, Day, Year)	9 2000 32. Re	egistrar's Signatur	2	Apon	Ka						

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State of Maryland / Department of Health and Mental Hygiene 14827 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Juanita **Physician** Eischer 4:35 17 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** Days 1□ M 21XF Hours 216 36 6994 Yrs 65 Director Jan. 8, 1935 Virginia Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Anne Arundel Millersville 10s. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 6 597 Belmawr Place must b 21108 permit. Pages 1 and 2 should be find within 72 hours after deat Department of health and Mental Hygiene. Important: if them 27 is marked other in any injury or other trauments other in the page. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Yes 2 No Specify: à 3 ™ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 (not available) Williams Rose (not available) 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Linda Whaley Daughter 1713 Wilkens Avenue Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 5/8/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Baltimore National Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ranerouser or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, that cause on each line. 23a Part1. Enter the disease shock, or heart failure. **Physician** Acute Myocardial Infarction /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Mitval Value Physician/Medical Examiner The law requires that the deeth certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last pue Due to (or es e consequenca of): P.O. Box 68760, attending physician for use as the burie Due to (or es e consequence of) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. ģ 24b. Were eutopsy findings evailable prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 200 No 1 ☐ Yes 2 1 No certificate or Attanding Physician: funeral director, 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA the state 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attanding within 24 hours effected.

To the Funeral Director: Affe completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) Medical 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) May 4. M 30, Name and eddress of person who completed cause of death (Item 200) (Type, Print) 30 L HUSpital Drive Glen Burnie, MD Wicks JEDVAL 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

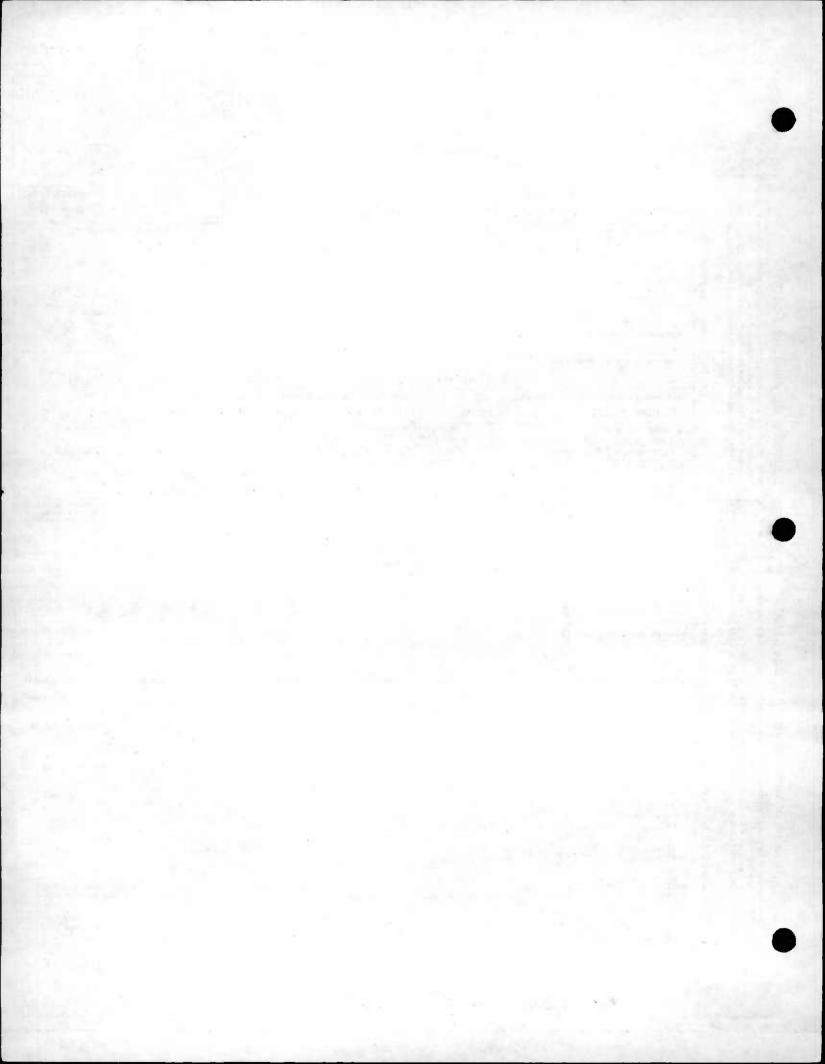
**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 14828 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year Physician Emelie D. Godfrey 2000 6:30 P.M. 6 May /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GilChrist Center TOWSON Bate of Birth (Month, Day, Year) **Baltimore** If Under 1 Year Birthplace (Steta or Foraign Country) 5. Sociaf Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Vrs Director 217-05-8424 May 11, MD Usual Residence of Decedent r 28a-f ahow 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Baltimore MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23e or 2 aminer must be or 10012 Van Winkle Lane USA Funeral 21220 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Yes 2 No. If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or h Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 MWidowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) permit. Pages 1 and 2 ahould be filed within 72. Department of Health and Mentei Hyglene. Important: if tem 27 ie marked other than "natienty injury or other traumatic event, the Medica SDBS. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Medical Secretary Medical 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be 0 Davis Terrence Mary Herget 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5434 DayBreak Terrace, Baltimore, MD Roberta Wertz/ Daughter 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) BALTIMORE, MD Metro Cremetery 5-8-00 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue, Rosedale, Md 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician TACHAEL CANCER /Medical fmmediate Cause (Final disease or condition resulting in death) 6 minter Examiner Examiner The lew requires that the death certificate be assecuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medicai Due to (or as a consequence of): d for use es ti Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? B 26. Place of Death (Check only ona) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2√2 No this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending invastigation To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: After Yompietely filled in by the fun 1 Yas 2 No 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 29a, Certifier 1\textsup Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner steted. 29b. Signature and title of certifia 29d. Data signed (Month, Day, Year) 29c. License number

**DHMH 16 Rev 6/95** 

State Registrar

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

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31. Data filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene amend item 23a,c pt. II G783 per phys. yg 5/9/00 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2000 YURIE **Physician** 30, April 2:30 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20300 Middletown Rd. Freeland Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 2, 19 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 213-28-2726 69 Yrs. 1930 Director Md. Usuel Residence of Deceden 10a. Stete 10b. County show 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Md. Baltimore Freeland 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20300 Middletown Rd. 21053 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
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Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lie 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to for as a con Physician/Medical Examiner attending physicien end for use es the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Lest Due to (or es e consequence of): Multiple Strokes (Cerebralvascular P.O. Box 68760 Accident) Due to (or es e consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? by the 1 Yes 2 700 3 Probably 4 Unknown signed Records, þ 8 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an eutopsy page 2 YORIC 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director 25. Wes case referred to medical 26. Place of Daeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 1 Alaturel 5 Pending within 24 hours after death.
To the Funeral Director: Af 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) To the Vithin 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000551 and address of person who completed cause of death (Item 23a) (Pype, Print) Street, Back were 6565 N. 32. Registrar's Signatu State Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY Voor PLEE (SRUBER 16:15 AM 2000 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SAMARITAN BALTIMORE (1TY BALTIMORE ff Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 10 M 20 F Yrs. 22032345 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes A Tho Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 219 Hopkins Road 21212 USA 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 □ Yes XX No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Procurement Specialist Hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ernest Farmer Charlotte Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Stephen R. Gruber Son 3658 Burkins Fload Street Maryland 21154 20a. Method of Disposition 1 DBuriel 2 ☐ Cremation 3 ☐ Removal from State 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, State Margan Chapel Church Cem. 5/5/00 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility nature of Funeral ServicesLicense Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 110 YRS HUPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequença of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy tindings aveilable prior to completion of cause ot death? 24a. Was an autopsy performed? 2DENO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

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permit. Peges 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: if them 27 is merked other them.

The law requires that the death certificate be axecuted and physician Physician: or Attending

Box 68760,

of Vital Records, P.O.

Division

funaral director, Aftar this s aftar death. Il Director: Aft ed in by tha fur filled in by

Medical Certification: To Be Completed To the Hospital o within 24 hours at To the Funerel D completaly

State Registrar

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) JOHN ROGERS 31. Date filed (Month, Day, Year)

MAY

29b. Signeture end title of cartities

1 Netural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 Could not be determined

GOOD SAMMEITAN 32. Registrar's Signature 9 2000

OSPITAL BALTIMORE, MO 21239

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29c. License number

28t. Location (Street and Number or Rural Route Number, City or Town, State)

CONTRACT YOUR CONTRACT YOUR

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4831 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Month Yee Constance E. Ganz 2000 9:05 AM May 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Jan 4 1910 6. Sex 7. Age (In yrs. last birthdey) Months Deys Hours 1□ M 2☑ F Yrs. 216-01-0979 90 Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Tyes 2√5 No Baltimore Arbutus Maryland 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zip Code 1242 Poplar Avenue U.S.A. 21227 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Black, Whita, etc. 11 Meritel Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married White 1 Yes 2₺ No Specify: Specify: 3<sup>™</sup> Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Cotlege (1-4or 5+) 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middle, Last) Julius Link Unknown 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Donel C. Ganz / son PO Box 680 Manchester, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) Loudon Park Cemetery 5/11/2000 Baltimore, Maryland 21. Signeture of Funerel Service License 22. Name and Address of Fecility Hubbard Funeral Home, Inc. 23a. Pent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Intervel Between Onset end Death Immediate Ceuse (Finel weeks disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2₽No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner physician end s the burial-transit certificate be executed Box 68760. esn ò P.0. by the signed b Records, The law requires peen page 2 has certificate Division of Vital this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera After

**Physician** /Medical

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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**Funeral** 

Director

with the Marylend

permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylen Department of Heath and Mental Hygiene. Important: If Item 27 is merked other than "naturel", or Items 23s or 28s-f show eny Injury or other treumstic svent, the Modest Examines must be notified at

altimore, Maryland 21215-0020

Physician/Medical by Completed Be 2 edical Certification:

25. Wes case referred to medicel exeminer? 1 Yes 2 No 27. Menner of Deeth 1-Naturel

5 Pending Investigation 2 Accident 6 Could not be 3 ☐ Sulcida 4 ☐ Homicida

28e. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Tima of

28c. Injury et Work?

1 Yes 2 No

29c. License number

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Less Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

(Check only one) 29b. Signature and title of certifier

29a. Certifier

2316S

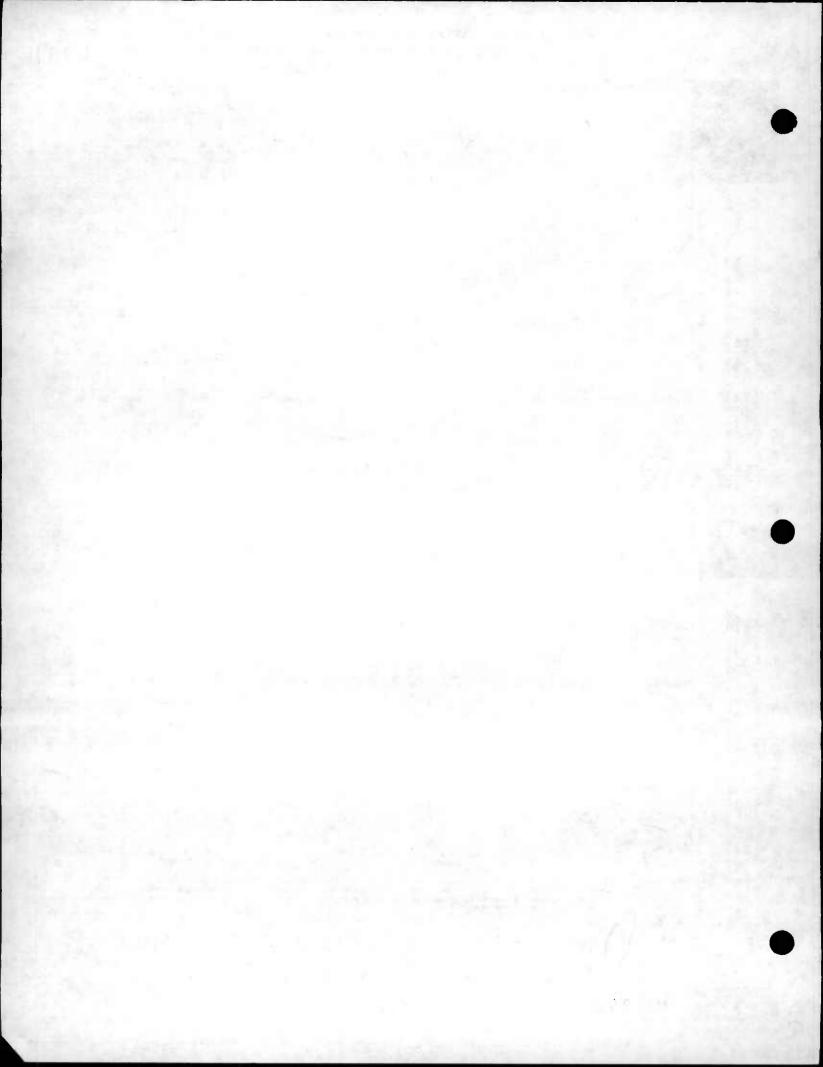
29d. Date signed (Month, Dey, Year) 8 00

30. Neme end ed ess of person who completed cause of death (Item 23e) (Type, Print) Steven ZIII Lawerer mm

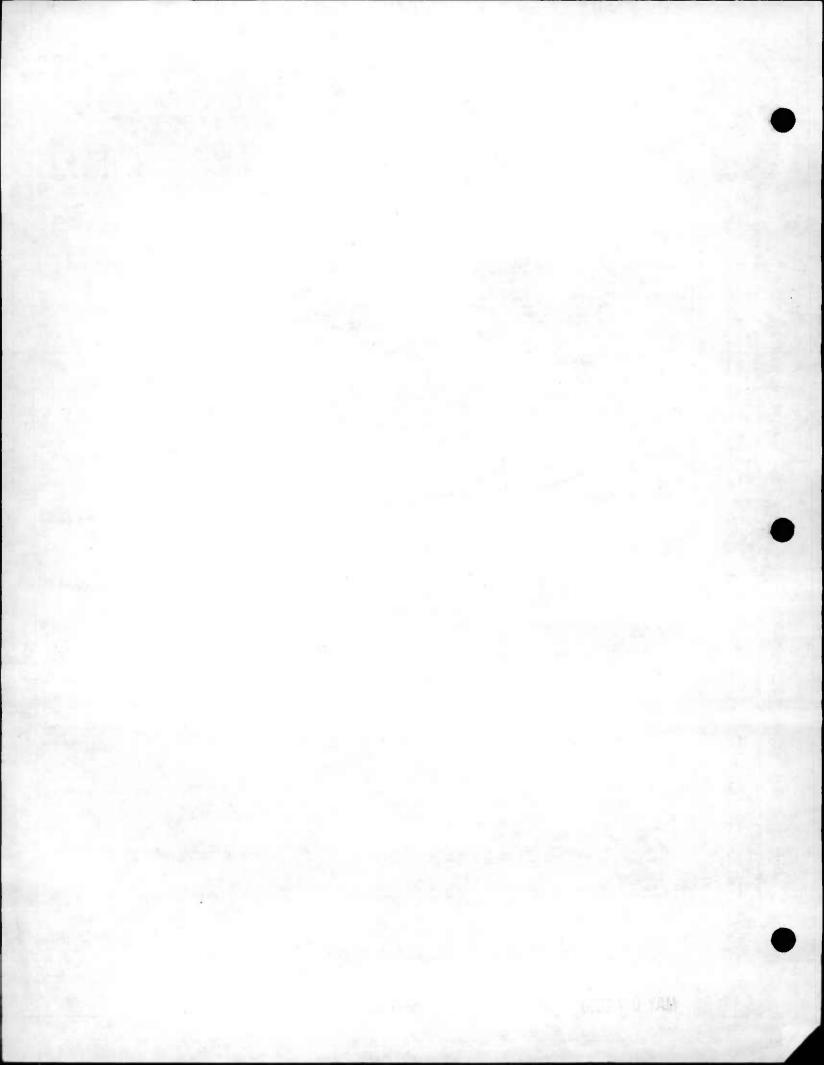
31. Dete filed (Month, Dey, Year) MAY 0 9 2000

32. Registrer's Signature

State Registrar



		State of	Maryland / De	partment of ertificate			nd Menta		jiene O	0	14832	
Physician	1. Decedent's Name (First, M.	iddle, Last)						te of Dee	th Dey	Year	3. Time of Death	
/Medical		eorge Gladhill					AD	ril	27	27 2000 2		
Examiner	4a Fecility Name (# not institu					4b. City, Town, or Location of			, , , , , , , , , , , , , , , , , , , ,			
	Washington 5. Social Security Number		PITAL  . Age (In yrs. last birthd	f Under 1 Y		lager	Stown	o of Righ	Wash			
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viet viet	238 Summit Avenue 21740									intry?		
r Herra 234 Arra man Funeral	11. Marital Status	12. Wes Deced	ent Ever in U,S.			spanic Origin	n? (Specify Ye	USA secify Yes or No- Pican, etc.)  14. Race - American Indien, Bleck, White, etc.				
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to Heelth and Mantal Hygiens. If item 27 is marked other than or other traumatic avent, trail To Be Comp	20a. Method of Disposition		20b. Place of Di	sposition (Neme or	of		Date		20c. Location			
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perimit. Fayes I and Department of Heelth Important: If Item 27 eny Injury or other to once.	21. Signature of Funeral Sens	certitoenages		22. Name end A	ddress	s of Fecility				,		
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hysician /Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	o. Mu	Uti On Due to (or es a con	gan	9	Rai	lur	2.			Onset end Death	
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Mysician and the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury)									3 days		
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director, page for Be Com	25. Was case referred to med examiner?	Hospitel:			Other	P*	Death (Chec					
ral dire	1 Yes 2 No	28a. Date of	batient 2 ER/Outpa			4 LI Nurs			ence 6 Oth		(b)	
After tine	1 Natural 5 □ Pen		Day Year) Injui	У	Injury Work	? es 2∐No						
el Director: After tied in by the funera Certification:	3 Suicide 6 Cou	ald not be 28e. Place of						281. Location (Street end Number or Rural Route Number, City or Town, State)				
A hour	29a. Certifier 1 Certifier (Check only one) Medic	ying Physician: To the best Examiner: On the basi and manne	is of examination and/o	eath occurred et the investigation, in	he time my opi	e, date end i	pleca, end due occurred et th	e to the c	ause(s) end m late and place,	enner es	steted. to the cause(s)	
within 2 To the comple	29b. Signature and title of cert	ifier	10	29c. Li	icense	number + ( L	172	) 2	29d. Date signe	Month,	Dey, Year)	
1)	30. Name and address of pers	on who completed cause	of death (Item 23a) (Ty	oe, Print)	ON	pd A	ve. He	age)	stou	m, of	D21740	
State Registrar	31. Date filed (Month, Day, Ye MAY 0 9 2000	Server 32. Agg	pistrar's Signeture	ale								



State of Maryland / Department of Health and Mental Hygiene 14833 Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Yaer Physician COMBE 2000 RUDE /Medical 4b. City, To Nama (If net institution, giva street and number) ition of D 4c. County of Deeth Examiner 15 MORTE 8. Date of Birth (Month, Dey, Year) 07-05-03 Birthplaca (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20F 20-3011 96 Director NC Uaual Residance of Dacedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits - Phow 1 Yas 2 No r than "natural", or items 23s or 28s-f short the Wedical Examiner naust be notified at Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8042 North Boundary Road 21222 USA Funeral death 12. Was Dacedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after a Department of Heelth and Mental Hygiene. Important: if frem 27 is marked other than "natural", or than any injury or other traumatic event, tra Medical Francis 1 Tas 25 No If Yea, Giva Yaar or Datas: 1 Navar Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: Black ð 3X Widowed 4 □ Divorced Completed 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) 9th Grade Collega (1-4or 5+) NA Nurses Aide Company 17. Fether'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 Unknown Hill Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21222 Alfonso Dickey 8042 N. Boundary Road Baltimore, Maryland 20a. Method of Disposition
11 Burial 2 Crametion 3 Ramoval from Stata 20b. Placa of Disposition (Nema of cematery, crametory or other placa) Data 20c. Location - City or Town, Stata Voshell Mem. Garden 05-08-2000 Dundalk, MD 4 ☐ Donation 5 ☐ Othar (Spacify) 22. Name and Addrass of Facility Baltimore, Maryland 21202 21. Signature of Funaral Sarvice Licanso WM.C.March FH 1101 E. North Avenue Do not antar tha moda of dying, such as cardiac or raspiretory arrest, Approximata Interval Between Onsat and Death 23a. Part1. Entar tha disaasa, or complications that caused the dishock, or haart failura. List only ona causa on each interest. **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in daath) NEUMONER Examiner Dua to (or as a consequance of) Examiner 101 physician and the buriel-transit certificate be assecuted Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last Dua to (or es a conseguence of): Box 68760 IMERS EMA edical Dua to (or as a consequanca of): Physician/M 980 for P.O. the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by ti Records, by 24b. Ware eutopsy findings eveilable prior to completion of cause of daath? 24a. Was en eutopsy performed? Completed peen hes page 1 Yes 22 No 1 ☐ Yas 2 ☐ No this cartificate of Vital Physicien: Be 25. Was casa refarred to medical 26. Placa of Death (Chack only one) Hospital: Nalinpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) 1 Yas No Medical Certification: To funerel 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Dascribe how Injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funere After Division 5 Panding Invastigation 1 Natural 1 Yas 2 No 2 Accidant 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stefa) 6 Could not be 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To tha best of my knowledga, daath occurred at the time, date and placa, and dua to tha cause(s) end menner as stated.

[2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data end place, end due to the cause(s) end mannar steted. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. Licanse number 29d. Data signed (Month, Dey, Year) D47287 30. Name end eddrass of person SHAR 31. Data filed (Marth Day)

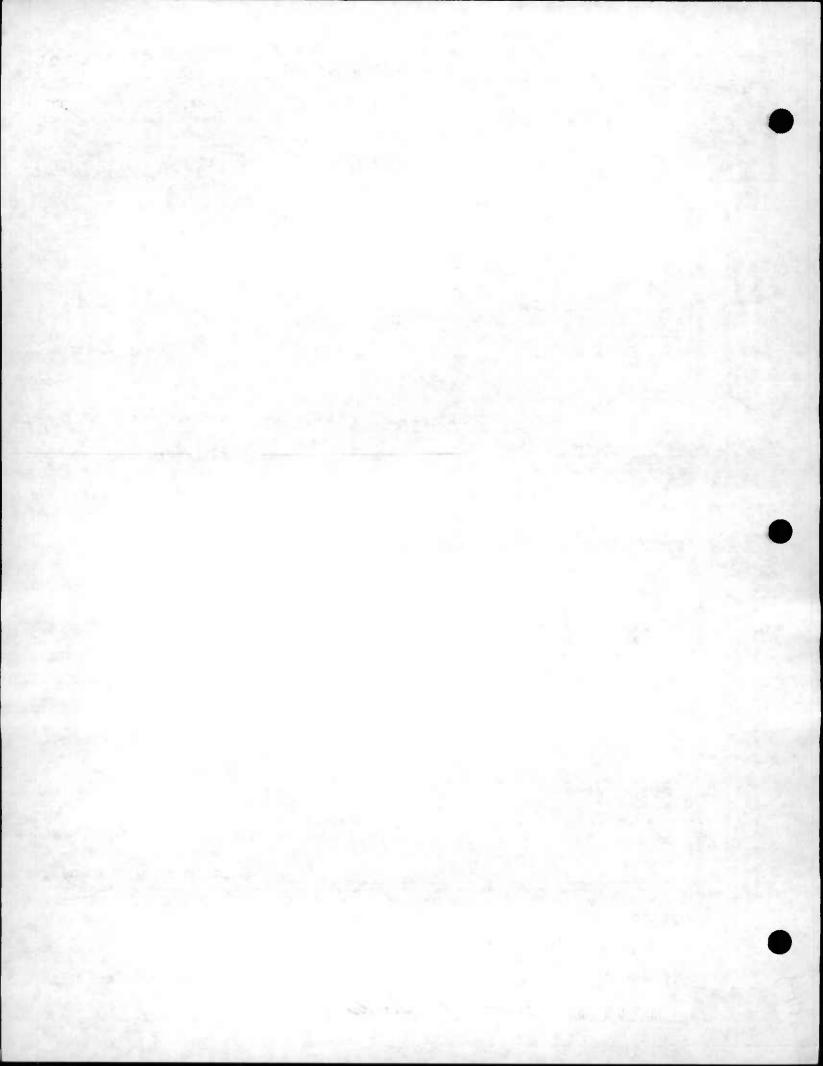
**DHMH 16 Rev 6/95** 

State

Registrar

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DOUGH VAN



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month **Physician** JAMES EDWARD 6:55 P.M. MAY 6 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F 214-16-5426 Yrs. Director VIRGINIA Usuel Residence of Decedant 10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho 1 Yes 2 No Directo NIA MARYLAND 10e. Street end Number og. Citizen of Whef Country? ST. APT9F 360 FRANKLIN USA Funeral 12. Was Decedant Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Detes: Harris . 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status permit. Pages 1 end 2 should be filed within 72 hours after. Department of Hasith end Mentel Hyglene. Important: If item 27 is marked other there any Injury or other the second statement of the second seco 1 Never Married 2 Married 1 Yas 2 No Specify BLACK Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation
(Giva kind of work done during most of working life. DO NOT use retired)

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16e. Decede 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) 12 + GRADE BALTO, CITY GOVERNHENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROSA KOVER RAWLE 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19e. Informant's Neme/Ralationship (Type, Print) LARL MATTHEWS (15 DANLOW DRIVE, BALTIMORE, MD. 21207 COUSIN 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) Data 20c. Location - City or Town, Stete 20e. Method of Disposition 12 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) NATIONAL CEMETERY 05-11-00 LAUREL, MARYLAND 22. Name end Address of Fecility
JOSEPH H.
2140 N. FULT of Funeral Se BROWN JR. FUNERAL HOME N. FULTON AVE. BALTIMORE. MO.21217 23a. Park Enlar the disease, or complications that ceused the deeth. Do not anter the mode of dying, such es cardiac or respiratory snick, or heart failure. List only one ceuse on each line. Approximeta Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel ventricular Unknown disease or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner ischema myocardia unknowy physicien and the burial-transit The law requires that the death certificets be axecuted Sequantially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): cardrovascular disease menony atherosclerotic Due to (or es e consequence of) use as P.O. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown of Vital Records, þ sate has been signated bage 2 should b 24b. Were eutopsy findings eveilable prior to completion of ceuse of daath? 24a. Wes en eutopsy performed? edical Certification: To Be Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No After this 28e. Date of Injury (Month, Day Year) tha funeral 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation s after deeth. 1 Yas 2 No 2 Accident 28f. Locafion (Street end Number or Rurel Route Number, City or Town, Stata) 6 Could not be datarmined 3 Suicide 28e. Plece of Injury - At home, farm, sfreef, factory, office building, atc. (Spacify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end place, end due to tha ceuse(s) and mennar es steted.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, death occurred et tha tima, data end place, end dua to the causa(s) and menner statad. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier

**DHMH 16 Rev 6/95** 

Hardy

State Registrar 31. Dete filed (Month, Day, Year) MAY 0 9 2000

Jon Faler MD

900 Caton Avenue Agnes Hospital 32. Regisfrer's Signature

MO

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

**ORIGINAL** 

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May

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Bulhwore, Mayland 21229

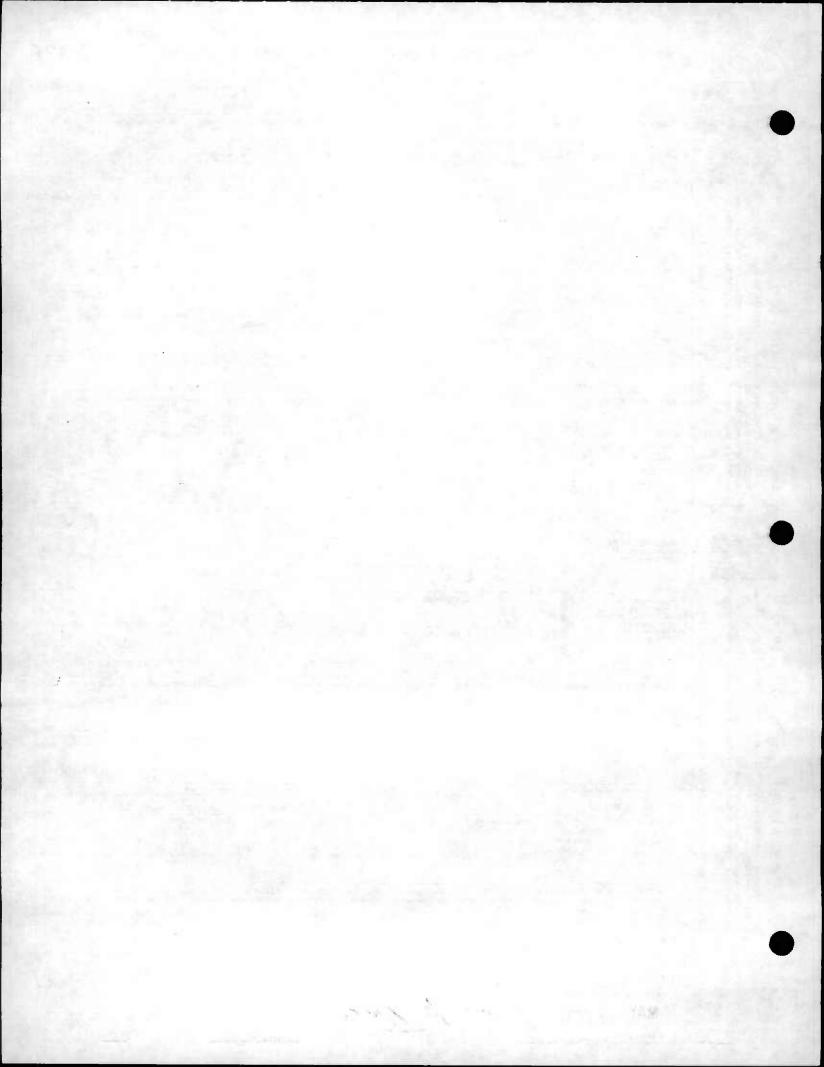
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State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death		Reg. No.	0 14000					
nysician	1. Decedent's Name (First, Middla, Last)	2. Data of Da Month		3. Tima of Death					
Medical	Nellie Hedler	May 3,		5:50 pm					
kaminer		or Location of Death	4c. County o	f Death					
<del></del>	Hamilton Nursing Center  Baltimo  5. Social Security Number  6. Sex  7. Aga (In yrs. last birthday)  If Undar 1 Year  If Undar 2 Year		N/						
neral ector	215-09-7595 1 M 200 94 Yrs. Months Days Hours Mi	n. (Month, Da		9. Birthplace (Stata or Foraign Country) Lithuania					
ed.est	Usual Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits					
Examiner must be notified at by Funeral Director	N/A			tttYas 2□No					
20	MD IV/A Baltimore  106. Street and Number 107. Zip Coda		10g. Citizan of W						
Funeral Director			US	•					
era	6305 Everall Avenue 21206  11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin?	(Specify Yas or No		- Amarican Indian,					
	Armed Forcas? If Yas, specify Cuban, Maxicen, Put	arto Rican, atc.)	Black	, Whita, atc.					
by	1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Yas 2 ☐ No Specify: Year or Dates:		Specify:	White					
bet	15. Decedent's Education 16a. Decedant's Usual Occupation	- 4.5	16b. Kind of Bus	inass/Industry					
pie	(Specify only highest grada completed)  (Giva kind of work done during most of work done during	vorking							
COT	8 Ø Home Maker		Home						
Be Completed	17. Father's Nama (First, Middla, Last)  18. Mothar's N	ama (First, Middla,	, Ma <i>idan Sum</i> ama	)					
Tol	Lawrence Luckus Marcel	le Mil	kalauskas						
	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Addrass (Street and Number or	Rural Routa Numb	er, City or Town, S	Steta, Zip Code)					
	Anna Beelat niece 4804 Frankford Avenu	e Baltimo							
	20a. Mathod of Disposition  20b. Place of Disposition (Nama of cemetery, crematory or other placa)  20c. Place of Disposition (Nama of cemetery, crematory or other placa)	Dete	20c. Location - C	City or Town, State					
	4 □ Donation 5 □ Othar (Specify) Holy Redeemer Cemetery	05-06-00	College	Park, Maryland					
	21. Signatura of Funeral Service Licensee 22. Nama and Addrass of Facility  Cary I. Kaufman S		**						
	Mark. Marshall Most Gary L. Kaufman S Pratt & Stricker	Outhwest	funeral	Home, Inc.					
	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or raspiratory a	rrast,	Approximata					
н	shock, or haart failura. List only one cause on each line.  Interval Batween Onset and Death								
	Immediate Cause (Finel disassa or condition resulting in death)  e. #\$ Pirctin Trev mo	200		1 month					
	rasulting in daath)  Dua to (or as a consequence of):	>V((							
edicai Examiner	- Stoke								
am	0.								
Û	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.								
2	that initiated evants resulting in death) Last Due to (or as a consequence of):								
5	d								
lan									
<b>Physician</b>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Dld	tobacco use con	tributa to the cause of death?					
P		10	Yes 2 2 No	3 Probably 4 Unknown					
Completed by		04- 111		24b. Were autopsy findings					
etec			an autopsy ormed?	available prior to complation of ceuse					
Ē			2/	of daath?					
S		10	Yas 2 No	1 ☐ Yas 2 ☐ No					
Be	25. Was casa rafarred to medical axaminar?  Hospital: Other: Other:	Daath (Check only	ona)						
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on	27. Mannar of Death  10 Netural 5 Pending investigation investin investigation investigation investigation investigation investi	28d. Dascribe	how injury occurre	O O					
cat	2 L'Accident	28f. Location /	(Circuit and Number	or or Rural Route Number,					
Ĭ	4 Homicida  28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)		wn, Stata)	or ribrar riodia ridilibar,					
Medicai Certification:	One Codding and Codding Development								
lica	29a. Certifying Physician: To the best of my knowledge, daeth occurred et the time, data end plated (Check only)  2 Medical Exemple: On the basis of examination end/or invastigation, in my opinion, deeth occurred.	ccurred et the tima,	data end place, a	ner es stetad. nd due to tha causa(s)					
Mec	29b. Signature and title of pertiller 29c. Licensa number		29d. Data signad	(Month, Day, Year)					
	14// 1)464	75	5.4	~ 90					
	1/11/	()	7						
	30. Name and address of person who completed causa of deeth (Item 23a) (Type, Print)	Bal	t. M	021237					
	31. Data filed (Month, Day, Year)  32. Registrar's Signature	D. (	1- /-(	1 (11)					
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	MAY 9 2000 person proces								
v 6/95	Maria di								

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:45 pm Walter E. Habighurst, Sr. MAI 6 2000 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing Home Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 123-M 2□ F 216017297 Yrs. 91 Director Maryland Usual Residence of Decedent death with the Mandand 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1218 Weddel Avenue Funeral 21227 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If Itam 27 is marked other than "natural", or item any injury or other traumatic avent, the Martin and once. Black, White, etc. 1 Yes 22 No ff Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 0 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Frederick Habighurst Myrtle Mariner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Anne Wasilewski /daughter 1218 Weddel Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from State Loudon Park Cemetery 4 Denation 5 ☐ Other (Specify) 5/9/2000 Baltimore, Maryland ature of Funeral Service Licensee 22. Name and Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Throwic Obstructive Rulmonary Ds /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Physician/Medicai Due to (or as a consequence of) attanding pl signed by the a of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yss 2 No 37 Probably 4 Unknown g 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has 2000 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred Certification: 28c. Injury at Work? al or Atternance and or Atternance and Director: After the for Division Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) To the Vithin 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month Day, Year)

MAY 0 9 2000

**DHMH 16 Rev 6/95** 

30. Name end address of person who completed ceuse of death from 23a) (Type, Print) Allen Reilly

32. Registrer's Signature

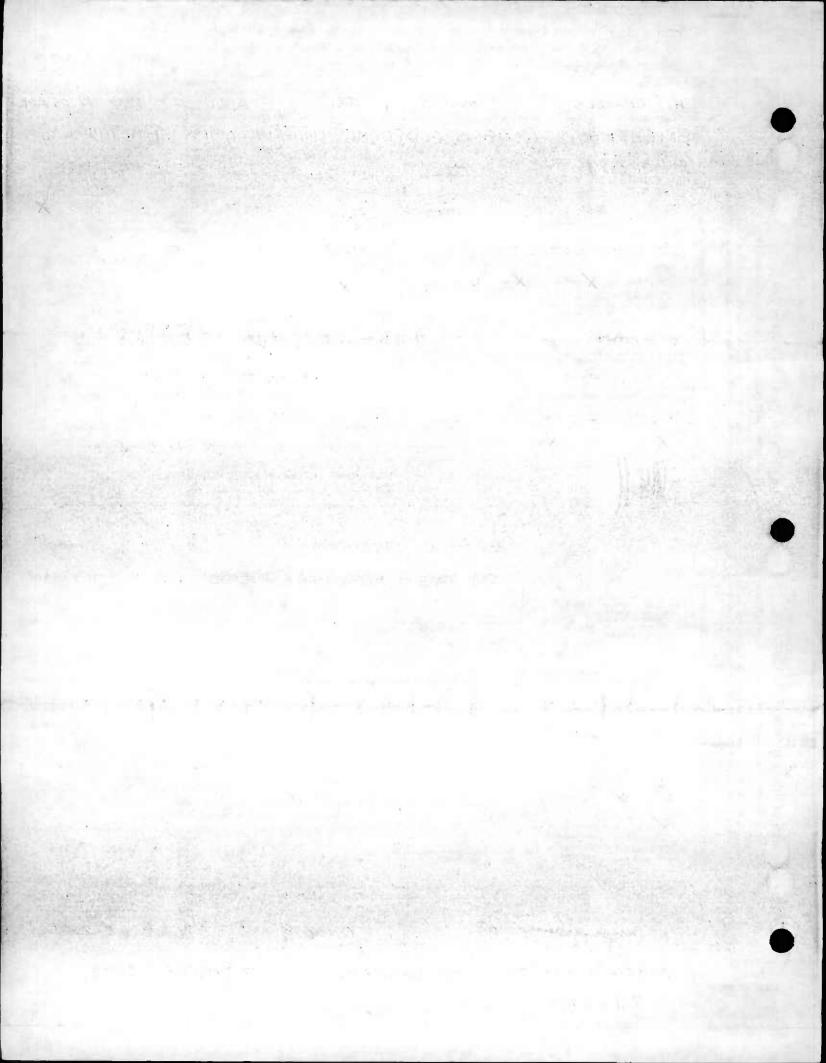
29c. License number

HUENUC

29d. Date signed (Month, Day, Year)

2000

	_	Decedent's Nam	ne (First, Middle, La	5–9–2000 JAI		00111	mouto o	f Death	2. Date of D		Yeer	3. Time of Dea
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iner I r	B 5. S	RIGHT Social Security N	WOOD 6. S	GENES	e (In yrs. la	st birthday)	If Under 1 Ye.	LUTTHERU ar   If Under 24 Hi	MUE, Mi	) T	3ALTI 9. Birthi	MORE_ plece (Stete or Fo
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		n. State PA	10b. County York			Town or Local	ition					10d. Inside City L
1	10				Yor	k	101 T- 0-1			40. 000	1115	1 □ Yes 2
niner must be notified at	106	o. Street and Nu		1024			10f. Zip Code			10g. Citizen of Whet Country?		
3	11.	Marital Status	h Queen Str	12. Wes Decedent	Ever in U,S		1740 as Decedent of	of Hispanic Origin?	(Specify Yes or N		Race - Ameri	
1	•	1 Never Marr	ied 2 Married 4 Divorced	Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates:	43-19	74 10	Yes 2, X N	uban, Mexican, Pue lo <i>Specify:</i>	erto Hican, etc.)		Black, White, ecity: Whi:	
		(Spec	15. Decedent's Ed	ducation ade completed)	- 4	16a. Deceder	nt's Usual Occ	cupation ne during most of w	orkina		of Business/In	
	E	Elementary/Seco	ondary (0-12)	College (1-4or 5	i+)	life. DO	NOT use ret	ired)			ge Mfg.	
	17	12 Father's Neme	(First, Middle, Last)	<del>i+</del>		Pres	stoeuc/G	eneral Mana	eme <i>(First, Middl</i>		oution C	Δ.
		Herbert C							[Eichelbe			
			ame/Relationship (	Type, Print)		19b. Mailing	Address (Stre	eet and Number or I		-	-	code)
			P. Hafey /					en Street,				
		. Method of Dis	position			nce of Dispositi	ion (Name of		Dete		on - City or T	own, State
		1 Burial 2 4 □ Donation	☐ Cremation 3 🔀 5 ☐ Other (Specifi	Removel from Stete		pect Hil		*	4/26/2000	4/26/2000 York, Pennsylvania		
any injury or pace.	21. Separation of Funeral Service Licensee  22. Name and Address of Fecility Baumeister, Orcutt & Small Mortuaries, In								Inc.			
	100	MADY		P. L. Branch Co.		75	1 South	Queen Stree	et, York,	PA 17403		
	23a. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. ASPIRATION PNEUMONIA											
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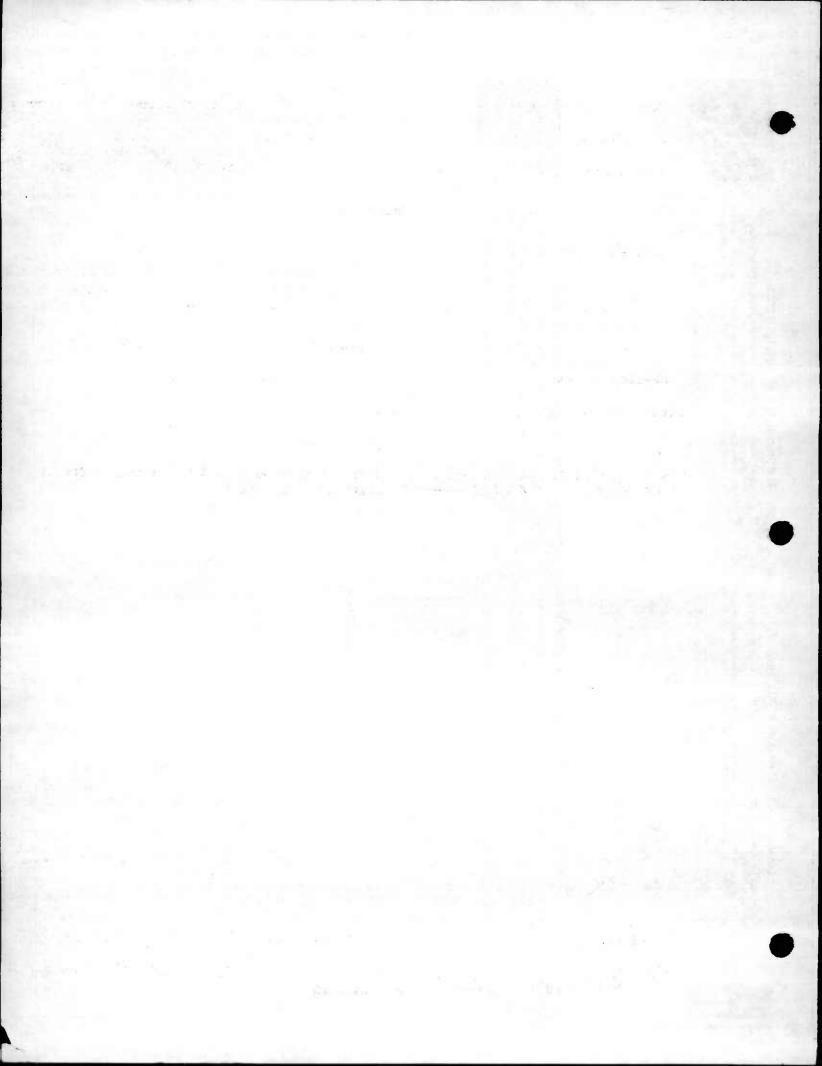
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14839 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Day 2000 Month **Physician** Yaar April 22, DONALD F. HUSEY 11:30 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Daath Examiner 2201 Pine Avenue Baltimore N/A Months Days Hours Min. Nov 30, 1922 6. Sax 1 M 2 □ F 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Months 77 MD Director 213-16-3367 Usual Rasidence of Decedant permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Department of Health and Mentle Ihygiene. Important: I filem 27 is marked other than "netural", or items 23s or 28s-f show any injury or other traumatic event, me Medical Engineer must be notified as 10a. State 10b. County 10c. City. Town or Location 10d. Inaida City Limits MD N/A Baltimore Director 1X Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2201 Pine Avenue 21207 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Race - Amaricen Indian. Black, Whita, atc. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: white Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilage (1-4or 5+) plumber residential 6 none 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Charles F. Husey Goldie L. Phillips 2 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Diane Clarke/daughter unknown 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4X Donation 5-BOthar (Specify) Signature of Euneral Service Licensee Ronald 6. Wade 22. Name and Address of Facility Board 655 W. Baltimore Street , Director Baltimore, MD 21201 238. Fart1. Entar the diseasa, or complications thet ceused tha daath. Do not enter the moda of dying, such as cerdiac or respiratory arrest, book, or haart feilura. List only one cause on each line. Approximata Intarval Between Onsat and Death Physician /Medical tmmediata Causa (Final disaasa or condition rasulting in death) 60M1N YOCARDIAC **Examiner** requires that the deeth certificata be executed buriei-transit Sequantially list conditions, if any, leading to immadiata ceuse. Entar Undarfying Cause (Diseasa or injury that initiated avants rasulting in death) Last pue physician s the buriel Records, P.O. Box 68760. Physician/Medical Dua to (or es a consequence of): Part ii. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Wara autopsy findings available prior to complation of cause Completed 24a. Was an autopsy 1 Tas 1 Yas 2 No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours efter deeth.

To the Funeral Director: After this certifics 25. Was casa rafarrad to medicel axaminar? Be 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral ( 27. Mannar of Death 28d. Dascribe how Injury occurred 28a. Data of injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 5 Pending 1 Yas 2 No 2 Accidant invastigation 3 ☐ Suicida 6 ☐ Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stete) filled in by 4 - Homicide 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) end menner as steted.
2 Medical Examinar: On tha bests of axaminetion and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and due to tha ceuse(s) and menner statad. Medical 29a. Certifier (Check only one) 29b. Signature and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Dey, Year) 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) 660 9 REISTERS TOWN Rd. BACTO no 2121

BHAT IAMI MO

Registrar

31. Data filed (Mornin, Day, Yay) 2000



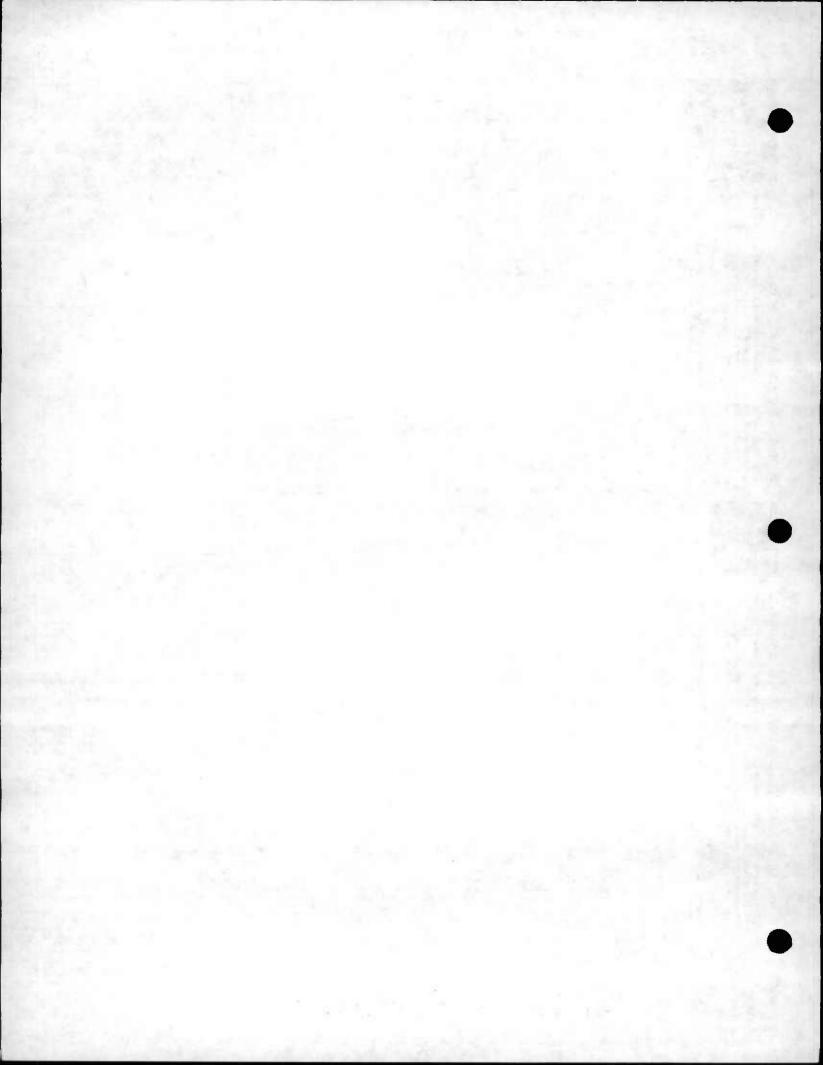
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 14840 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Hernandez YOTU **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Glen If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** XXM 2DF Months Deys Yrs. Philippines 45 14,1954 230-35-3086 Nov. Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mental Hygiana. net of Health end Mental Hygiana. nt: If Itam 27 is marked other than "naturs!", or items 23a or 28a-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at MD Anne Arundel Crofton 1 ☐ Yes 🎗 😾 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21114 1465 Blockton Court USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indien. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. Nover Merried 2 ☐ Married White Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 Hote1 Credit Manager 17 Fether's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Ernest K. Sulit Gumersinda Hernandez 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Lyndall C. Wiley (Fiance) 1465 Blockton Court, Crofton, MD 21114 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 05/09 1 ☐ Burial ②Cremation 3 ☐ Removal from State permit. Page Depertment o Important: If any injury or once. = 6 Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Baltimore, MD 21. Signature of Funerel Service Licens 22. Name end Address of Fecility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and for use as tha buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Box 68760. by the a Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of death? as been signed by 2 should be datac 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed' has s certificate ha 1 Yes 2 DINO 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Wes case referred to medical exemple? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Menper of Deeth 28c. Injury et Work? Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by tha f 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funaral Compiataly filled 29a Certifier 1 Pertifying Phyetclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*D\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). Medical 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 31. Dete filed (Month, Day, 32. Registrer's Signet MAY 0 9 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Examiner	4e Facility Name (If not institution, give:	spital Cen	tor		0 11.	ore	4c. County	N/A		
Funoval	5. Sociel Security Number 6. Sec		st birthdey)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey			ce (Stete or Foreign	
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	11. Maritel Status  1 □ Never Merried 2 🗷 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1. ☑ Yes 2 □ No 1954 If Yes, Give Yeer or Detes: 1969	4-	as Decedent of H Yes, specify Cub	lispenic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race Bled Specify	e - American k, White, etc	3.	
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State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's Signetu	الم الم	100	us.					



State of Maryland / Department of Health and Mental Hygiene 14842 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** VIRGINIA HAYMIRE EDNA May 6,2000 11:30am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) | ff Under 1 Year | lif Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign Country)

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-**Funeral** 10M 25F Vrs Director 214-20-8945 AN 2 1925 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director BALTIMORE me 25a or 28a-f Md BALTIMORE 10a. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 2523 ROAD 21234 USA WENDOUER Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after Hygiene. ther then "natural", or its 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 DWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) th BANKING CLERK 12 FIRM . Pages 1 and 2 should be flied w firment of Health and Mental Hygies tant: If Item 27 is marked other to jury or other traumatic event, to NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) å PARSONS GEORGE LABIN EDITH 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: If item 27 any injury or other to CT<sub>o</sub> Dete VEANNE 9910 SHOSHONE WAY RANGALISTOM, Md 21133 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1月 Burial 2 ☐ Cremation 3 ☐ Removel from State GARDENS OF FAITH 4 □ Donation 5 □ Other (Specify) 00 BALTO. 22. Name and Address of Fecility,

If PRTLY MILLER 21. Signeture of Funeral Service License FUNERALHOME, CHTD. HARTLY BALTO Md, 21234 752 HARFORD 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Inocardial Examiner Due to (or es e consequence of): Examiner pertension ettending physician end for use as the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Unknown Breast cancer Records, þ 5 8 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No certificate Division of Vitai or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 topatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 ☑ Neturel 2 ☐ Accident 5 Pending investigation n 24 hours after deeth.

• Funerel Director: Afte deethy filled in by the fun 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and menner and menner and menner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely if (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) D-0054805 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC Department, 6701 N. Charles St. Billimore, MD 21204 Emergency SOHN HING 32 Pingistrar s Signature 31. Date filed (Month, Day, Year) State 9 2000 MAY

Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 14843

1. Decedent'a Name (First, Middle	le, Last)							2. Date of Do Month	eath Day	Year	3. Time of Death
	Mar	gherita	Isola	abella	a			May	3	2000	6:00 P.M
4a Facility Name (If not institutio	on, give street and	number)			4	b. City, To	wn, or Lo	cation of Deal	h 4c. Cou	nty of Death	
Mariner Heal	th of No	rth Aru	nde1			Glen	Burr	ie	Anne	e Arun	nde1
5. Social Security Number	6. Sex		rs. last birthday	) If Unde	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. Birth	plece (State or Foreign
220 72 0418	1□M 2X	F 90	Yrs.	MONTHS	Days	nours		June 2	2, 1909	Tu	rkey
Usual Residence of Decedent											
10a. State 10b. County	1	10c.	City, Town or L	ocation							10d. Inside City Limits
Maryland Anne Arundel Glen Burnie  106. Street and Number 107. Zip Code									1 ☐ Yes 200 No		
10e. Street and Number				10f. Zi	ip Code				10g. Citizen	of What Cou	intry?
	Drive				2106	1		1.50	Thir	kev	
313 HOSPITAL I		Decedent Ever in	U.S. 13.	. Was Dece			ain? (Spe	city Yes or N		lace - Ameri	ican Indian,
1 Never Married 2 Mar		Forces? es 25 No		If Yes, spe	ecify Cuba	an, Mexican	, Puerto	ecify Yes or No Rican, etc.)	6	Black, White	, etc.
3 ☑ Widowed 4 □ Divorced	If Yes,	Give or Dates:		1 ☐ Yes	2 X No	Specify:			Spe	city: W	hite
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17. Father's Neme (First, Middle,		3 - T				18. Mothe					
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19a. Informant's Name/Relations				_					er, City or To		
Maria Hutching	gs / N	iece	7709	Lee	Driv	re	Pas	adena,	Maryla	and 21	.122
20a. Method of Disposition			. Place of Disp cemetery, cre	position (Na	ame of	ne)		Dete	20c. Locatio	on - City or T	own, State
1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		om State	len Hav	ren Me	emori	al Pa	rk 5	/8/00	Glen E	Burnie	, Maryland
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DHMH 16 Rev 6/95

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Year OO 6.15pm Mary Jackson Jones 30 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE N/A 2930 SILVER HILL AVE. If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Months Deys Hours 10 M 20 F 221-26-009 62 VA Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 11☑ Yes 2 ☐ No Baltinon N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2930 (1) UJA 21207 Wes Decedent Ever in U.S. Armed Forces 14. Race - American Indian, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Yes 2 I If Yes, Give Yeer or Detes: 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) -12--4-DIRECTOR DAYCARE

18. Mother's Name (First, Middle, Maiden Surname)

20c. Location - City or Town, Stete

5-5-2000 BALTIMORE, MARYLAND

5-4-2000

Baltmon no 21237

ELLA B. JACKSON

Dete

22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A.

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2930 SILVER HILL AVE. BALTIMORE, MARYLAND 21207

**Physician** /Medical Examiner

Departmant of Haalth and Mental Hygis Important: If Item 27 is marked other I any injury or other traumatic event, II

**Physician** 

/Medical

Examiner

10e. Stete

mo

17. Fether's Neme (First, Middle, Last)

20a. Method of Disposition

4 Donation

21. Signature

HERMAN P. JACKSON SR.

JAMES JONES (HUSBAND)

Fanerel Service Licans

1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete

5 NOther (Specify) ENTOMB

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

mo

32. Registrer's Signeture

mcCillum

31. Dete filed (Month, Dey, Year)

MAY

19e. Informent's Name/Relationship (Type, Print)

**Funeral** 

Director

Pagas 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haalth and Mental Hygiene.

Baltimore, Maryland 21215-0020

arked other than "natural", or flams 23a or 28a-f show atic event, the Madical Examiner must be notified at

**Funeral Director** 

Completed by

Be 2

Medical Certification: To Be Completed by Physician/Medical Examin

physician and s the burial-transit The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, usa To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifics completally filled in by the funeral director,

23a. Party Enter the disease, or comp shock, or heart failure. List only o Immediate Ceuse (Finel disease or condition resulting in deeth)	licetions that ceused the deer one cause on each line.	th. Do not enter the mo	de of dying, such es cardia	ac or respiretory errest,	Approximate intervel Between Onset end Death
	Due to (	or es e consequence of			
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (	or es e consequenca of)		N. C. C. C. C. C. C. C. C. C. C. C. C. C.	
Cause (Disease or injury that initieted events resulting in deeth) Lest	Due to (d	or es e consequence of)		· · · · · · · · · · · · · · · · · · ·	
Pert II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	cause given in Pert I.	23b. Did tobacco use contrib	ute to the cause of death?  Probably 4 Unknown
				performed?	lb. Were eutopsy findings available prior to completion of cause of death?
ne Wassessafessafessafes				1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ② No
25. Wes case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2	ER/Outpetient 3 D	Othori	eath (Check only one)  Home 5 PResidenca 6 □Other (5	Specify)
27. Menner of Deeth  1 Neturet 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, facto fy)	y, office	28f. Location (Street end Number of City or Town, State)	r Rurel Route Number,
				ca, end due to the ceuse(s) end manne curred et the time, date end place, end	
29b. Signeture end title of certifier		20	c. License number	29d. Dete signed (M	lonth Dev Year)

Franklin Square Down

20b. Place of Disposition (Name of cametery, cremetory or other place)

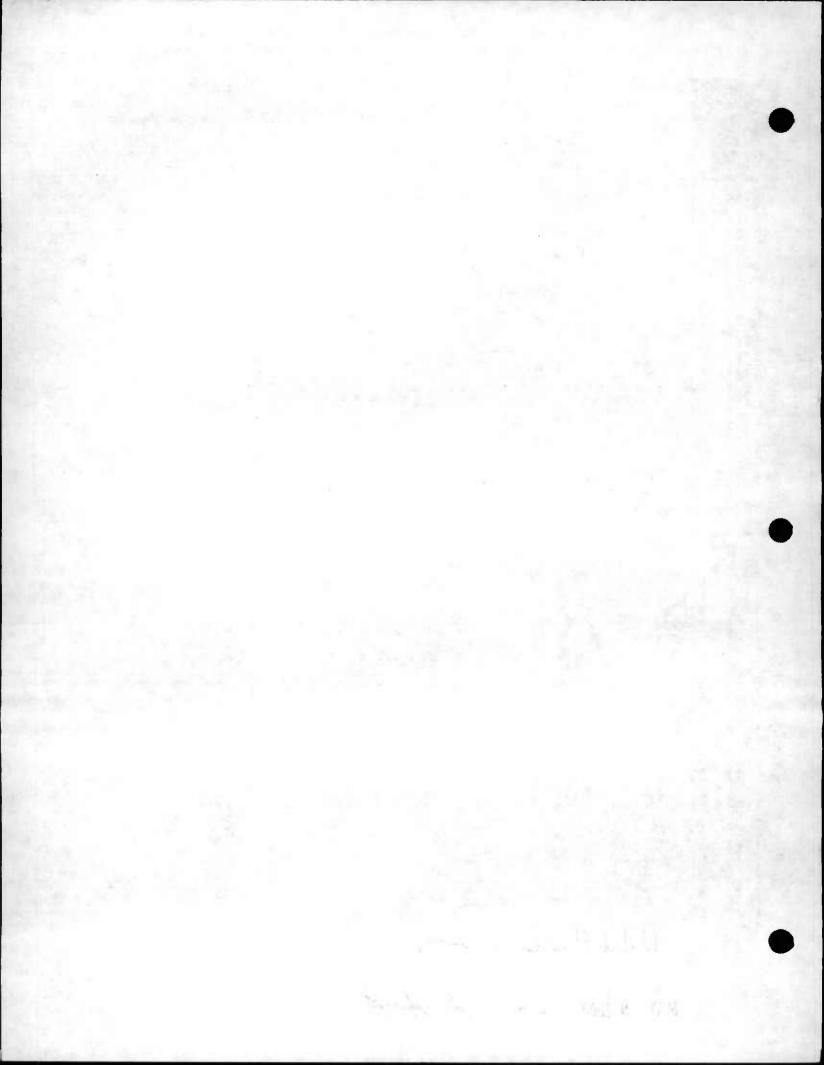
WOODLAWN CEMETERY

**DHMH 16 Rev 6/95** 

State

Registrar

9105



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4845

1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Physician Barbara Ann Johnson 05 2000 6:30 PM May /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore 1556 Sulphur Spring Road Arbutus If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dete of Birth Month, Pay, Year) 46 Mary Land 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Deys 10 M 10 F Months Hours 54 218-44-1695 Director Usual Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after death with the Manyland neat of health and Mental Hygiens.

Int: If item 27 is marked other than "natural", or items 23s or 28e-f show that if you have the marked other than "natural", or other traumatic event, the ledgest Emminer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 Tho Director Maryland Baltimore Arbutus 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1556 Sulphur Spring Road 21227 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried Merried White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Beautician/Owner Beauty Salon 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Norris Lee Aletha Jane Duvall 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1556 Sulphur Spring Rd., Arbutus, MD Thomas M. Johnson/Husband 21227 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location · City or Town, State 20a Method of Disposition permit. Pagas 1
Department of H
Important: If ite
any injury or ot
once. 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 5/10/00 Cedar Hill Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MacNabo Funeral Home, P.A. regarde Edward A Gregorchik 301 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) ancer years Examiner Due to (or as e consequence of) Examiner The lew requires that the death certificate be executed the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): usa of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cervical Cancer History þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27 Menner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 X Natural I Director: Aff 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

To the Hospital o within 24 hours aff To the Funeral DI completely filled in

State Registrar

9 2000

Street Orleans 32. Registrer's Signeture

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

**DHMH 16 Rev 6/95** 

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31. Dete filed (Month, Day, Year)

(Check only

29b. Signature end title of certifier

State of Maryland / Department of Health and Mental Hygiene 00 11,81,6

TEM #26 P	ER FH G783 5	5/9/2000 AH			Cert	ificate of	Death	200	Reg. No.	00	14040
Physician	ELHEI							2. Deta of D Month	Dey	Yeer	3. Time of Death
/Medical	Ecuer				l			May		2000	8:04am
Examine	401 E	E. 25th	give street end num Street	Apt.4E			4b. City, Town, or L Baltimo	ore	I.	NA	
Funeral Director	5. Social Security	7029	Sex 1□MXXXF	7. Age (In yrs. lest	Yrs.	If Under 1 Year Months Days		8. Dete of B (Month, D 02-2	irth ley, Year) 6-22	9. Birth	plece (Stete or Fore intry) MD
		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									10d. Inside City Lim
show at mit											x1 Yes 2 1
Director	MD		IA	Bal	timore 101. Zip Code			10g. Citizen of Whet Co			
			Street A	pt. 4E		2121		USA			
hy Funeral		s arried 2 Married d 4 Divorced	Armed Fore	No No	U.S. 13. Wes Decedent of Hispenic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto f				ecify Yes or No- Rican, etc.)  14. Race - American Black, White, etc.  Specify: Black		
		15. Decedent's pecify only highest	Education		6e. Decede (Give ki	nt's Usuel Occu	upetion a during most of work ad)	16b. Kind of Business/Inc			ndustry
To a. State   10b. County   10		College (1-	4or 5+)		_	ea)					
		NA		Lau	ndry		Company				
						18. Mother's Nam		(First, Middle, Maiden Sumeme)			
		Unknow					Unkn				
	19e. Informent's	Neme/Reletionship	(Type, Print)	1	9b. Mailing	Address (Stree	et and Number or Ru	ral Route Num	ber, City or Tox	vn, Stete, Z	p Code) 212
	Lilli	ie Mae J	ohnson	Carter	6142	Dunro	ming Roa	ad Bal	timore	e, Ma	ryland
	20a. Method of D	Disposition		20b. Plece	of Disposit	tion (Neme of		Dete	20c. Locatio		
Lillie Mae  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  20a. Method of Disposition  21. Signatur of Funeral Service							Garden (	05-10-	2000 I	Dunda	lk,MD
à	4	Funeral Service Lie			22.1	Neme end Addi	ress of Fecility D	altimo	xo M:	ryla	nd 2120
ouce	I I	+	1								
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	shock, or h	eert feilure. List or	inplications that ca by one cause on ea	used the deeth. L ich line.	o not enter	the mode of dy	ring, such es cardiec	or respiretory	errest,	1	Approximete Intervel Between Onset end Deetl
attending physician end for use as the buriel-transit	Ceuse (Disease that initieted eve resulting in death	conditions, immediate iderlying or injury nts h) Lest	c	Due to (or es							
Physician		nificant conditions	d	ath but not resultin	g in the und	derlying cause g	iven in Pert I.	23b. Die	tobacco use	contributs	to the cause of de
Phy	Dia	betes	5					10	Yes 254	0 3□ Pr	obably 4 Unk
Completed by	Hy	perto	nsion					24a. Wes en eutopsy performed?		8	Vere eutopsy findin- veileble prior fo ompletion of cause f deeth?
Como	11		1.1	0				10	Yes 20 No	1	☐Yes 2☐No
Ü	25. Was case re	formed to medical	uste	rocen	(11					,	_ 163 Z_ 100
8	examine?		Hospitel:			-/-0	26. Plece of Dee				
To B			1 1 1		Outpatient b. Time of	3 LOUA	4 LI Nursing H		sidence 6 🗆		eify)
Certification:	1 Neturel	5 Pending	28a. Dete of (Month)	n, Day Year)	Injury	28c. Inj		280. Describe	how injury oc	curred	
Ca	2 ☐ Accident	Investige	t he				☐ Yes 2 ☐ No		(0)		10 . 11
=	4 Homicid		ad Zoe. Fleue	of tnjury - At home g, etc. (Specify)	, ferm, stree	et, factory, office	9	28t. Location City or T	(Street end Nu own, Stete)	imber or Ru	rei Route Number
Ö											
edical		1 Certifying 2 Medical Ex	Physician: To the baseniner: On the baseniner	sis of examinetion	dge, deeth o end/or inve	occurred et the estigetion, in my	time, date end plece opinion, death occu	, end due to the rred et the time	e ceuse(s) end e, dete end plac	menner es ce, end due	stated. to the ceuse(s)
Medical Ce		nd title of certifier	-	8	)	29c. Licer	nse number		29d. Date sig	ned (Month	, Dey, Year)
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1	30. Neme end ac	Idress of person wit	no completed cause	of deeth (Item 23	e) (Type, P	rint) fat	ricia	Jish	aroo	ros	
	3414	St. Yau	elst.	Balli	more	e, M	0 217	18			
State	31. Dete filed (M	AY 9 2	nnn 3é. Re	gistrer's Signeture	4	1	1				
gistrar			UUU A	-	M	4000					

MAY James YAM

State of Maryland / Department of Health and Mental Hygiene

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				Cer	uncau	e or i	Death		Re	eg. No.		
sician	1. Decedent's Name (First, Middle,	Last)							2. Date of Deat Month	h Dey	Yeer	3. Time of Death
ledical	ROSE JACKSON								May 4,	2000		0455
aminer	4e Facility Neme (If not institution, and Memorial Hosp		•			4	_		cation of Death	4c. County		
			Age (In yrs. last	hirthday)	if Under	1 Yeer	East		8. Date of Birth	18	1bot	ana /Stata ar Forni
eral tor	528-12-3870	1□M 2/5√F	83	Yrs.	Months	Deys	Hours	Min.	(Month, Day, 10 Feb	Year) 1917	Count	ece (Stete or Forei
	Usuet Residence of Decedent											
	10a. State 10b. County		10c. City, T	own or Lo	cation						10	Od. tnside City Limi
Director		n Anne	C	enter	vill	e						1 ☐ Yes ⊉☐Ý
눔	10e. Street and Number				10f. Zip	Code			11	0g. Citizen of \	What Count	try?
	116 Gadd Drive			1			617			USA		
Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Merried	12. Was Deceder	s?	J,S. 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuben, Mexican, Puerto I				Rican, etc.)		e - America ck, White, e		
by	3√√Widowed 4 □ Divorced	1 ☐ Yes ②☐ If Yes, Give Year or Dates		1	☐ Yes	2 X X0	Specify:			Specify	whit	e
	15. Decedent's	16a. Decedent's Usual Occupation					16b. Kind of B	usiness/Ind	ustry			
Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondery (0-12)  College (1-4or 5+)						ing					
Com	12 Homemaker									ie		
Be	17. Fether's Neme (First, Middle, La	st)	18. Mother's Name (First, Middle, Maiden S Emily Maines					Aaiden Suman	10)			
2	Emitt O'Neil						Emil	у Ма	ines			
	19a. Informent's Name/Relationship					-			el Route Number			Code)
	Patricia Walker	- Daught					ive,	Cent	erville			
	20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremetion 3	☐Removel from Stat	20b. Plece	tery, crem	etory or o dge I	ther plea MAM	PK	į	Dete 5/9	20c. Location - Elkrid		
,	4 Donetion 5 Other (Spec		1					T				
	21. Signetur of Funerel Service Lic	Constant					ss of Fecili		nk Funer Glen Bu			
	Kelly Chego										MD 21	001
	23a. Pert1. Enter the disease, or co shock, otheart failure. List on	erfplications that caus lly one ceuse on each	ed the death. Dine.	o not ente	er the mod	e of dyin	g, such as	cardiac	or respiretory erre	est,	i	Approximete Interval Between Onset end Deeth
ו	Immediate Ceuse (Final				0 1		2	6			1 .	Criser end Deeth
	diseese or condition resulting in death)	0.	ronay	Y	Me	7	<u></u>	he	ase			713
ē		Ca	Due to (or aft	a consequ	uence of):	- 4	- 4	30	laa			910
直	Sequentially list conditions	<b>b</b>	Que to for as	a consequ	unnon offi-		1		-		1	19
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Amae.	ton	- in						1	4-1
Ical	that initieted events resulting in death) Lest	c	Dus to (or as	a consequ	ence of):						<del>- i</del>	
New Year	Tooling in doday cost		Anne	lin !	den	سار	١				1	42
		d	V	P	4							
/sic	Pert ii. Other algnificant conditions	contributing to death	but not resultin	g in the un	derlying c	ause giv	en in Pert l		23b. Did to	bacco use co	ntribute to	the cause of deat
P.									1 🗆 Ye	s 2□No	3 Prob	ably 4 tonkno
1 by									04-144	25	24h Wa	re eutopsy findings
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												leeth?
mpi									1□ Ye		1	Yes 2□ No
Completed by Physician	OF Mean and and an advant			0.4	• • • • • • •	Oth	or.		(Check only on	***	10 11	
Be	25. Wes case referred to medicat exeminer?	Hospital:	Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho							w injury occur		"
To Be	exeminer? 1 Yes 2 No 27. Manner of Deeth	1 lnpa		o. Time of	2	BC. Injur	, ,					
To Be	exeminer? 1 Ves 2 No  27. Manner of Deeth 1 Neturel 5 Pending	28e. Dete of In			M 2	Wor	k? Yes 2□					
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director  Funeral Director  Funeral Director  4c. County of Death Presbyterian Home of Maryland  5. Social Security Number 6. Sex 10 Maryland  5. Social Security Number 6. Sex 10 Maryland  5. Social Security Number 6. Sex 10 Maryland  5. Social Security Number 6. Sex 10 Maryland  6. Sex 10 Maryland 89 Mrs.  10 Maryland Baltimore  10 M	eca (Steta or Foraign n)  Land  od. Inside City Limits  1  Yes 2 No ny?
Medical Examiner   GRACE   LOUISE   JOECKEL   May 4, 2000   Standard   May 4, 2000   May 4	Telesca (Steta or Foraign ny) Land Inside City Limits 1 □ Yes 2 No ny?
Examiner  4e Facility Nama (If not institution, give street and number)  Presbyterian Home of Maryland  Funeral Director  4e Facility Nama (If not institution, give street and number)  Presbyterian Home of Maryland  5. Social Security Number 212-28-7034  1 M 2 F 89  4e. County of Death Towson  Towson  Baltimore Months Days Hours Min.  Presbyterian Home of Maryland  5. Social Security Number 212-28-7034  1 M 2 F 89  4e. County of Death Months Days Hours Min. Days Hours Min. Dec. 22, 1910  Presbyterian Home of Maryland  Baltimore Months Days Hours Min. Dec. 22, 1910  Presbyterian Home of Maryland  Baltimore County Months Days Hours Min. Dec. 22, 1910  Presbyterian Home of Maryland  Baltimore County Months Days Hours Min. Dec. 22, 1910	Telesca (Steta or Foraign ny) Land Inside City Limits 1 □ Yes 2 No ny?
Presbyterian Home of Maryland  Towson  Baltimore  Funeral Director  Presbyterian Home of Maryland  5. Social Security Number 212-28-7034  Towson  Funder 1 Year  1	eca (Steta or Foraign n)  Land  od. Inside City Limits  1  Yes 2 No ny?
Funeral Director  5. Social Security Number 212–28–7034  6. Sex 1 Months Days Hours Min. Dec. 22, 1910  9. Birthple Country Months Days Hours Dec. 22, 1910  9. Birthple Country Marry.	eca (Steta or Foraign n)  Land  od. Inside City Limits  1  Yes 2 No ny?
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Maryland Baltimore Towson  10e. Street and Number  10g. Citizen of Whet Country  400 Georgia Court  11. Merital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Raca - Armerical Black, White, et Bla	1 ☐ Yes 2 ☑ No ry? an Indien, etc.
Maryland Baltimore Towson    Maryland Baltimore   M	ry?
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400 Georgia Court  11. Merital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Bleck, White, et Bleck, White, et Bl	etc.
11. Merital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Bleck, White, et Bleck, White, et	etc.
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15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Businass/Indu	
3 Www. Widowed 4 Divorced Was or Dates:  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  12 years  14 yes 2td No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  Own Home	,
Elementery/Secondary (0-12) College (1-4or 5+)  12 years  Homemaker  Own Home  17. Father's Name (First, Middle, Last)  Frank  Frank  Morroan  Morroan	
T 🗦 " 17. Father's Neme (First, Middle, Last)	
Frank Morgan Elizabeth Helwig	
Frank Morgan Elizabeth Helwig	
	L008)
Sue Duel 400 Georgia Court Towson, Maryland 21204  20e. Method of Disposition 20e. Place of Disposition (Name of completely cremetry or other place)  Date 20c. Location - City or Tow	
1 TRucial 2 Companies 2 Decreased from State cametery, cremetory or other place)	vn, State
Druid Ridge Cemetery 5-12-2000 Pikesville	,Maryland
Druid Ridge Cemetery 5-12-2000 Pikesville  21. Signature of Funeral Service Licensee  22. Name end Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc.	
Mitchell-Wiedefeld Funeral Home, Inc.	1010
George Company of the Board of	Approximete
shock, or heart failura. List only one cause on each line.	Intervel Between Onset end Death
Sician	
disease or condition rasulting in death)  aminer  Alzheimer's Disease	1055.
Due to (or as e consequence of):	
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initieled events resulting in death) Last  Due to (or es a consequence of):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the conditions conditions contribute to the conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions conditions	the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to to 1 Yes 2 X No 3 Proba	ably 4 Unknow
58 6	
24e. Wes en autopsy performed? 24b. War evel	ra autopsy findings ilable prior to
24e. Wes en autopsy performed?  24b. War evei com of da 1 Yes 2 No 1	npletion of cause laath?
1 Yes 2 5 No 1	Yes 2 No
	1103 263110
25. Wes casa refarred to medicat examiner?  1 Yes 2 No	
£ 7	)
27. Manner of Death 27. Manner of Death 28a. Date of Injury 28b. Time of Injury et Work? 2 Accident investigation 3 Suicide 6 Could not be 28a. Date of Injury 4 home farm street factory office. 28b. Injury et Work? 1 Yes 2 No	
2 Accident investigation M 1 Yes 2 No	
27. Manner of Death   Matural   5   Pending   28d. Date of Injury    Route Number,	
29a. Cartifler (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, end dua to the causa(s) and mannar as sta	ated. tha causa(s)
and manner stated.  29b. Signeture and title of certifier  29c. License number  29d. Date signed (Month, D	Pay Veer!
29b. Signeture and title of certifier  Attending mb 29c. License number 29d. Date signed (Month, D 770/6 mgs 4	O O O
() () () () () () () () () () () () () (	2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kenneth M. Green, and 6701 N. Charles St., Set 415 By Hunn, and	2/204
State 31. Dete filed (Month, Day, Year)  32. Registrar's Signature	

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** MAE JONES J Mai /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Hospital Center Baltimore Square Kosedale tranklin 8. Dete of Birth (Month, Dey, Year) May 5 1920 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months 1 M 200F 216-28-4960 80 Director Georgia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD **Baltimore** Essex 1 ☐ Yes 2 No Director 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 1720 Henry Ave. 21221 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Status hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Maryland 21215-0020 8 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker own home 3rd 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental 2 Clark J Lawrence Sophronia Chastain 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) rportant: If item 27 is Virginia Ross / daughter 7026 Dunbar Road Baltimore Md. 21222 Baltimore, 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c Location - City or Town State Dete cemetery, cremetory or other place) to ty Burial 2 □ Cremetion 3 □ Removel from State 5/9/2000 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore Md. 21. Signature of Funerel Service License 22. Neme end Address of Fecility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused my death. Do not enter the mode of dying, such as cardiac or respiratory errest.

300 Mace Ave. Baltimore Md. shock, or heart feilure. List opty one cause on each line. Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final ongestivehear duxeks diseese or condition resulting in death) Examiner Examine physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last Diabe Box 68760. Physician/Medical USB BS P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 200 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveilable prior to been si 24e. Wes en eutopsy performed? Completed completion of cause of death? has The 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpetient 3 DOA this funeral To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? Division 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted. 29e. Cartifier

State

31. Dete filed (Month, Dey, Year) Registrar MAY 0 9 2000

(Check only one)

29b. Signeture end title of certifier

Daniel Alexander 9000 Franklin Square Drive Baltimore Maryland 21237 32. Registrer's Signeture

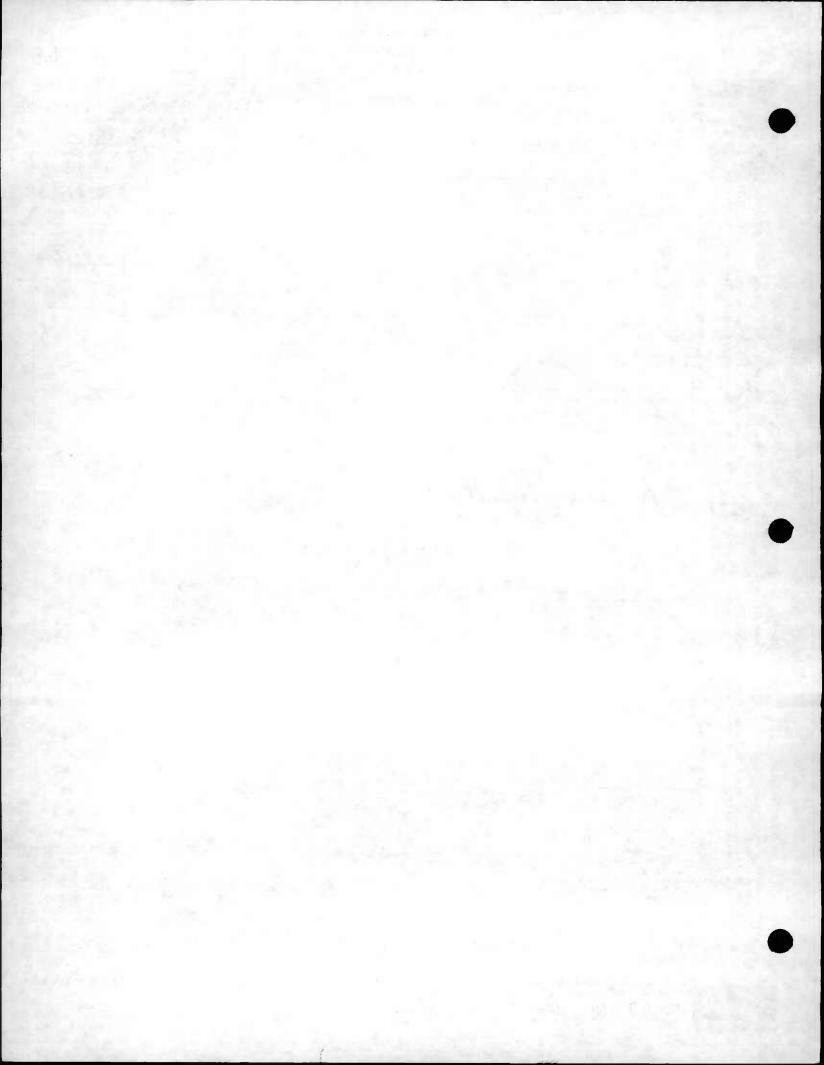
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

059812

29d. Dete signed (Month, Dey, Year)

may 5,2000



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State of Maryland / Department of Health and Mental Hygiene

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ysician	1. Decedent's Neme (First, Midd	ile, Last)					2. Date of De Month	eeth Day	Yaar 3.	Time of Deeth	
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aminer	4e Fecility Neme (If not Institution 776 Washingto					Balti		N/			
eral ctor	5. Sociel Security Number 220-82-0446	6. Sex 1 □ M 2 □ F	ga (In yrs. lest b 35	Yrs. If Unc Month	ler 1 Year s Days		in. 8. Date of Bi (Month, Di 06-1	rth ey, Year) 9-64	9. Birthplece Country) West	(State or Foreign Indies	
4	Usuel Rasidence of Decedant  10a. State 10b. Count	у	10c. City, To	wn or Location						nside City Limits	
Director	MD	NA	Bal	timore						Yes 2□No	
al Dire	10e. Street and Number 776 Washing	ton Blvd.	Apt.#8	t.#8 21230					10g. Citizen of What Country? USA		
edeal Examiner must be notified at leted by Funeral Director	11. Maritel Status  XI ☑ Never Merried 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Give	7		edent of I becify Cub 2 No		(Specify Yes or Nerto Ricen, etc.)	Bled	e - American Inck, White, etc.		
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				2450		18. Mother's I	Name (First, Middle				
	Jame	_			Kathl		Coo	-	21220		
		ship <i>(Type, Print)</i> Watts	15	b. Mailing Address 1634 S	herw	ood Av	Rurel Route Numb	ber, City or Town, ltimore	State, Zip Cod e, Mar	yland	
	1X Burial 2 ☐ Cremetion		cemei	of Disposition (A ary, crematory of Zion C	r othar ple		Deta +09-200		City or Town,		
	21. Signature of Funeral Service	Licensee	_	22. Name	end Addre	ess of Fecility	Baltimo 1101 E.	re, Man	_		
	diseasa or condition resulting in deeth)  Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events	a	Due to (or es o	consequence of conseq	of):	ISM AND	DEHYDRAT	LION			
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65	Z L Modidont	1 ☐ Inpat 28a. Data of Inj (Month, Di		Outpatient 3  Time of Injury	28c. Inju	4 LI Nursin	g Home SORes 28d. Describe	idance 6 Oth how injury occur			
completely filled in by the funeral  Medical Certification:	3 Suicide 6 Could 4 Homicide	mined 286. Pieca of it	jury - At home, tc. (Specify)	ferm, street, fect	ory, office		28f. Location City or To	(Street end Numi own, Stata)	ber or Rural Ro	uta Number,	
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	Stroben S	who complated causa or		111	Penn	Street	, Baltim	ore Mar	valend 2	1201	

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 114851

hysician //Medical xaminer and profited in the notified in the	214-01-1062  Usual Rasidence of Decedant  10a. Stata  10b. County	Inson  Nospital  Sax  1 M 2 M F 8  Anne's	10c. City, Town	Yrs. Months	er 1 Yaar S Days	4b. City, Town, 4 Eastor If Undar 24 H Hours M	rs. 8. Data of Bir	Day 2000 4c. County Talk	9. Birthpl Count Mar	3. Tima of Death  1030 AM  laca (Stata or Foraign  ry)  and  Od. Insida City Limits					
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1	Kendall Johnson (	(Son)				ast 23rd				s,FL. 3330					
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Completed by Physician/							24a. Was	an autopsy ormed?	ava	ara eutopsy findings ailabla prior to impletion of causa daeth?					
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5	30. Nama and addrass of person who Eric R. Ciganek.				:00-	nd o	entrevill	20 111	01/17						

DHMH 16 Rev 6/95 **ORIGINAL** 

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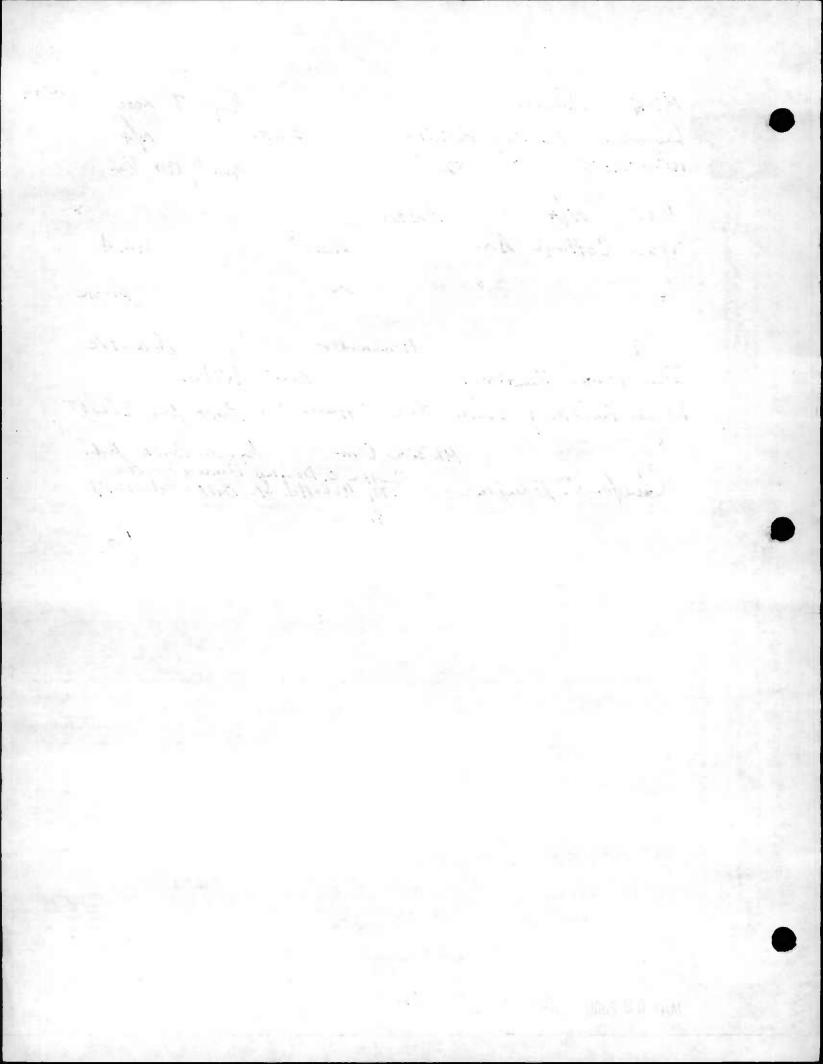
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Ē	1 □ Never	Married 2 Married	1 □ Yes 2	2 Ma No	13. Was Decedent of If Yes, specify Cu	ben, Mexican, Puerto	Rican, etc.)	Black,	, White, etc.
þ	3 Widow	wed 4 Divorced	If Yes, Give Year or Dai		1 Yes 2 N	Specify:		Specify:	Black
8		15. Decedent's	Education	16a	Decedent's Usual Occi	pation		16b. Kind of Busi	iness/Industry
ple	Fuertie	(Specify only highest g			(Give kind of work don life. DO NOT use retir	e during most of work ed)	ing		,
To Be Completed	Elementery	/Secondery (0-12)	College (1-	4or 5+)	Home make	-		Lone	stic
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ğ	Jal.	Henry	E Lle			Bessie	11:15		
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	1 -	- 1/	1.71	_	Neiling Address (Street	ge Ave		r, City or Town, S	3 1 2 11
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	20e. Method o	of Disposition	☐Removel from S	cometo	ry, crematory or other pi	ece)	Date	20c. Location - C	city or Town, Stete
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once. To Be Comp	21. Signature	of Funeral Service Lic	ensee			ess of Fecility less	France	& Swain	e
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n	shock, o	or heert failure. List on	ly one cause on ee	ch line.					Approximate Interval Betwe Onset end De
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Completed by	Part II. Other 1			th but not resulting in	n the underlying cause g	iven in Part I.	1 🗆 1	res 2□ No 3	24b. Were autopsy find available prior to completion of cau
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DHMH 16 Rsv 6/95

Minne Jamsun



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4853 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 6:30 P.M. John W. Jackman May Sr. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Harbor Hospital Center Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 18 M 2□ F Yrs. 74 April 15,1926 Director 212 20 8178 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow "natural", or items 23s or 28s-f ahor 1 ☐ Yes 2X No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21060 II.S. 1019 Twin View death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiona. Important: If Item 27 is marked other than "natural", or flee eny injury or other traumatic avent. It is the first to the statements as the statement of the s 1X Yes 2 □ No If Yes, Give Year or Dates: W.W. II 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Sergeant 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Beatrice Neville Leo Parr Jackman To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 Dorothy Jackman Wife 1019 Twin View 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 5/9/00 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician end s the burial-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated marks.) Box 68760 Physician/Medicai that initiated events resulting in death) Lest 80 ettending p USB 23b. Did tobacco uss contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has 1 Tyes Division of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Medical Certification: To 1 Inpatient this 28a. Date of tnjury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending Investigation 1 Yes 2 No Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner es steted.

1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) and manner stated. 29a. Certifie npletely ! (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01 albick 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

TAYATRI

31. Date filed (Month, Day, Year)

MAY

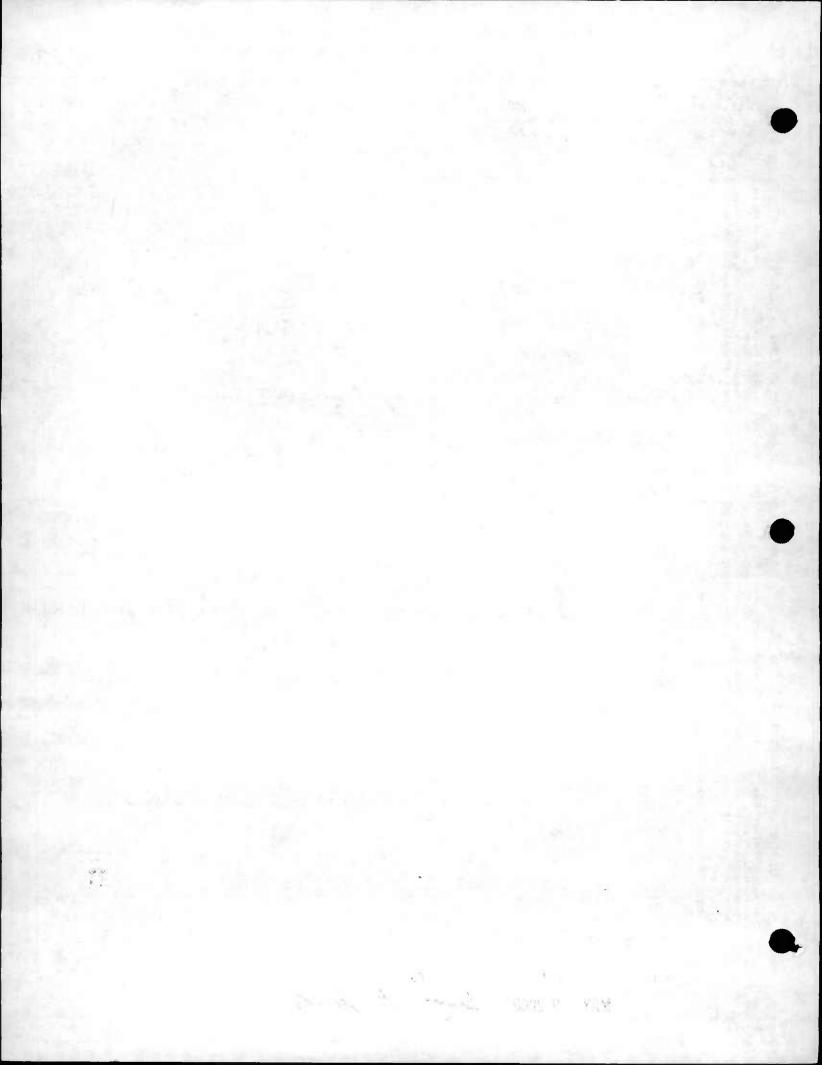
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32. Registrar's Signeture

2000

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ate of Maryland / Department of Health and Mental Hygiene	00	
Certificate of Death Reg. No.	UU	
2 Pate of Pooth		_

14854 1. Decedent's Neme (First, Middle, Last) Month **Physician** Mark Muir Kent MAY 2000 1611 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GLEN BURNIE If Under 24 Hrs. 8. Da NORTH ARUNDEL HOSPITAL ANNE ARUNDEL If Under 1 Year 8. Date of Birth (Month, Day, Year) May 28 1966 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1X M 2□ F 33 004-62-4020 Director Maine Usuel Residence of Decedent deeth with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Severn Anne Arundel 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 825 Elmhurst Road 21144 USA Funeral Herne 14. Race - Americen Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Menitel Stetus Armed Forces:
1 No 19 Yes 2 No
18 Yes, Give 1983 pemit. Peges 1 end 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "naturel", or ite any Injury or other treumatic event, the Medical Examina 1 ☐ Never Merried 2 ☐ Married altimore. Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify specifiwhite ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Self-employed Landscaping 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Guy I. ... Kent Gray Nancy 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Matthew M. Kent (Brother 10866 Bethesda Church Rd., Damascus, Md. 20872 e of Disposition (Name of Dete 20c. Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition May 12 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Maryland Veterans Cem. Crownsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name end Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122 Approximete Interval Between Onset end Death o not enter the mode of dying, such es cardiec or respiratory errest, **Physician** /Medical Immediate Ceuse (Fine disease or condition resulting in death) Examiner Examine the deeth certificate be executed burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Box 68760. Physician/Medical the Due to (or es e consequence of) 80 esn. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings eveileble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? hes 2 No of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funerel Director: After this certifical completely filled in by the funerel director, to 25. Wes case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To No 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 【 DOA 28b. Time of Injury 3:09 P 28d. Describe how injury occurred 27 Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Division 1 Naturel
2 Accident 5 Pending investigation motorcycle affragor in Accident 1 Yes 2 No 5/6/00 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

STICET

28f. Location (Street and Number or Pural Flouts Number, City or Town, State) (JUNIAN State) (JUNIAN State) (JUNIAN STATE) (JUNIAN STAT 3 Suicide 4 Homicide 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number OCME MAY 7, 2000 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Mil JAGK M 111 Penn Street, Baltimore, Maryland 21201

Registrar

State

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene

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14855

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death cardificate be executed in 24 hours after death.  The Hospital or Attending Physician: The law requires that the death cardificate besecuted by the attending physician and in 24 hours after death.  The Hospital or Attending Physician: The law requires that the death card Maryland be described by the attending physician and in 24 hours after death.  The Hospital or Attending Physician the Maryland or Hospital Brammer that the Maryland with the Maryland with the Maryland with the Maryland with the Maryland William Brammer that Maryland William Bram	and an include			Cer	tificate of	Death		1	Reg. No.					
	1. Decedant's Nama (First, Middla, Last)  ROBERTA  KEETS  2. Data of Death Month Day AV 3 2 6										3. Time of Death			
	4a Facility Name (If not institution,			AL		4b. City, To		ocation of Death	h 4c. County of Death					
To the Hospital Order of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.  To the Funerat Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director, page 2 should be deteched for use as the burial-transit of the funeral director. To Be Completed by Physician/Medical Examiner.	5. Social Sacurity Number 212-02-3912	6. Sex 1 □ M 2 1 F	7. Aga (In yrs. last b	last birthday) Yrs.  If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min.				8. Data of Birt (Month, Da Apr 26,	y, Yaar) 9. Bii C 1917 M		irthplaca (Steta or Foraign Country) ID			
9 -	Usual Residence of Decedent						1400							
Marylar a-f show illed at	MD 10b. County N/A			ty.Town or Location Baltimore						0d. Insida City Limits 1  Yas 2  No				
ire ire	10e. Street and Number				10f. Zip Coda				10g. Citizan of	What Coun	try?			
M S S S S S S S S S S S S S S S S S S S	1111 Park Aven	ue #614				21	201			USA				
	11. Marital Status  1 Nevar Married 2 Marrie	Armed Forces?  Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☒ No			Vas Decedant of li Yes, specify Cub	oan, Maxica	ecify Yas or No- Rican, atc.)		ce - Amaric ck, Whita, y: b1					
d Len bour														
ote ete	15. Decedent's (Specify only highast	s Education grada completed)	16	16a. Decedent's Usuat Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)						16b. Kind of Business/Industry				
The same of the sa	Etamentary/Secondary (0-12)	Cotlega (1	Cotlega (1-4or 5+) lifa. DO NOT usa ratired)											
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/land dental H red oth fic even To Be	17. Fathar's Nama (First, Middle, L Robert Colema:			18. Mothar's Nama (First, Mi										
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TE ANT	30. Name and address of person w	to complated cause			1, -						1 1 4 4 5			
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Anna Elizabeth Kunnapa 2000 May 05 3:00 am /Medical 4a Fscility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 618 Sutton Drive Pasadena Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days 1 M 3 F 84 Yrs Director 215-34-9533 Oct.22 1915 Estonia Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene. Ifem 27 is marked other than "natural", or hems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified as Pasadena Md. Anne Arundel Co. 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Sutton Drive 21122 USA Funeral 12. Was Decedent Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Meat Factory 12 Laborer pemit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, Important: if Nem 27 is marked othe any Injury or other traumatic event 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e Gustav Laanekorb Alide Weinberg 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 267 N. 6th Street, Brooklyn New York Leena Kutti (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 5/06/00 Baltimore, Md. Green Mount Cemetery 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122 23a. Part Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on a chiline. **Physician** Immediata Cause (Final diseasa or condition resulting in death) /Medical Examiner The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and pertension physician s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Onknown Records, by 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed completion of causa of death? 1 Yes 22 No 1 ☐ Yas 2 No certificate Division of Vital director 8 25. Was casa refarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Homa 5 M Residence 6 Othar (Specify)

Injury at 28d. Describe how injury occurred 2 1 Yes 2 No 3 DOA this 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending invastigation or Attending n 24 hours after deeth, the Funeral Director: After pletaly filled in by the fun 1 Tyes 2 No 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funerel D completely filled i Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end mennar es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and titla o 29c. License number 29d. Date signed (Month, Day, Year) ohn State 2000 Registrar

**DHMH 16 Rev 6/95** 

9 JOBS 6 ASK

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4857 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2 Data of Death 3. Tima of Death Month Edna Eva Kudlick May 6 2000 9:50 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Yaar Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 6 Sax 7. Age (In vrs. last birthday) Months Days 1 M 2 X F 212 22 1022 Yrs Dec. 17, 1908 West Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Insida City Limits Maryland N/A 1X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 West Talbot Street 21225 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: If Yes, Giva Year or Datas: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker (not available) Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Ettie Alma Thompson Luther Winton Lilly 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joyce Houck / Daughter 212 West Edgevale Road Baltimore, Maryland 21225 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Glen Haven Memorial Park 5/10/00 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Gonce Funeral Home P.A. romewelle 4001 Ritchie Highway Baltimore, Md. 21225 23a/Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset and Death CARDIO VASC ARTERIOSCLERATIO Due to (or as a consequence of) Disease Due to (or as a consequence of)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be flie Depertment of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event ance.

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Saltimore. Maryland 21215-0020

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27. Manner of Death  1  Natural		28b. Time of Injury	М	28c. tnjury e Work? 1 ☐ Ye		28d. Dascribe how in	jury occurred		
			oma, farm, stree fy)	t, fac	28f. Location (Street City or Town, St	and Number or Rural F ate)	loute Number,		
29a, Certifier		ysician: To the best of my kno							

and mann 29b. Signature and little of certifier

29d. Data signed (Month, Day, Year) DO2519 00

1 ☐ Yas 2 ☐ Ne

30. Name and address of person who completed causa of death (ttem 23a) (Type, Print)

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State Registrar

2 32. Registrar's Signatura

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 1:42 an M 2000 0 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth redical Cente Baltinose If Under 24 Hrs. 8. Date of E Birthplace (State or Foreign Country) 8. Date of Birth Month, Dey, Yeer) MAR 2, 1932 If Under 1 Yee 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6. Sex Months Deys Hours 1 M 2 F 218-26-2759 68 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No N/A Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5017 Goodnow Rd., Apt. 1D 21206 USA 12. Was Decedent Ever in U.S. Aymed Forces? 1.6 Yes 2 □ No 1956/ If Yes, Give 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Military Police 12 Airforce 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Mack Langley Mary Moragne 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Catherine L. Davis/sister 1818 French Santee Rd., Jamestown, SC 29453 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Metro Crematory, Inc. 5/9/00 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral 6 <sup>22</sup> Name end Address of Fecility Cremation Society of Maryland, Inc. C Dawn McDonal'd Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heef feilure. List only one cause on each line. Approximete Intervel Between Onset end Death tmmediete Ceuse (Finel diseese or condition resulting in deeth) week week Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 3 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 □ Impatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner steted. 29a. Certifier (Check only one)

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**Physician** 

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at DDR.

**Physician** /Medical

Examiner

altimore, Maryland 21215-0020

State Registrar

**DHMH 16 Rev 6/95** 

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30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

29b. Signature end title of certifier

32. Registrer's Signeture

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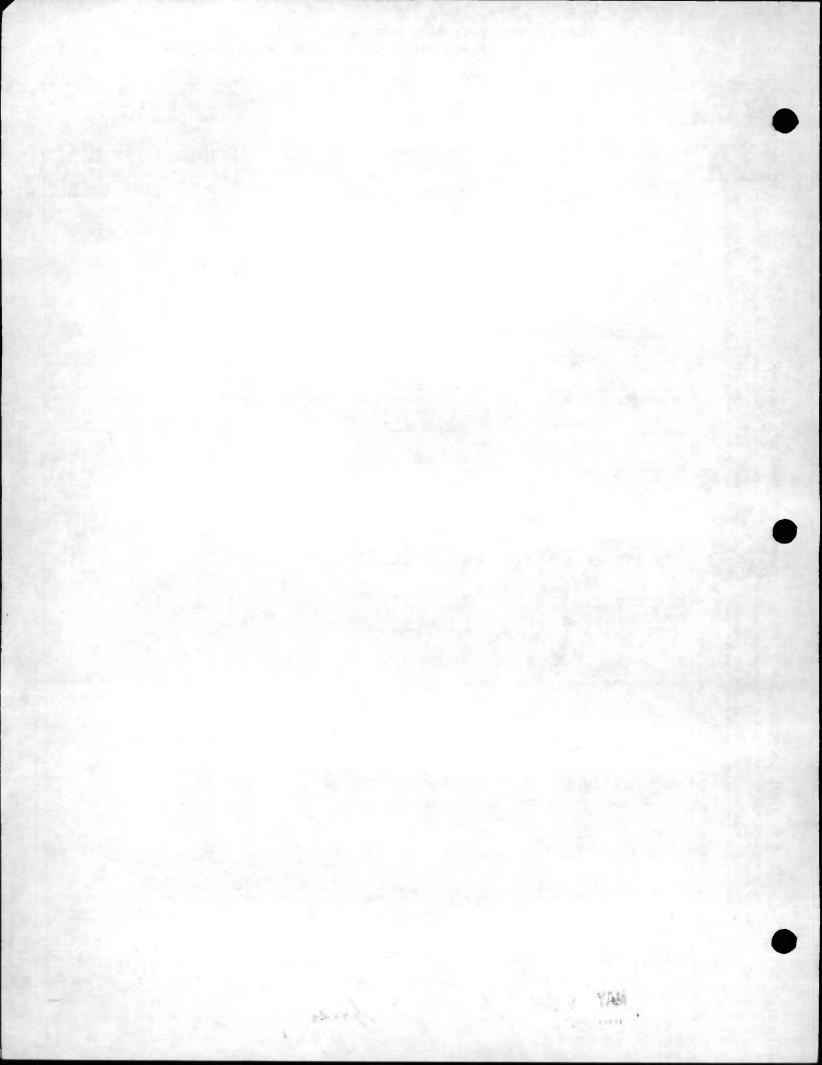
29c. License number

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29d. Date signed (Month, Day, Year)

Bayview Medical Ct.

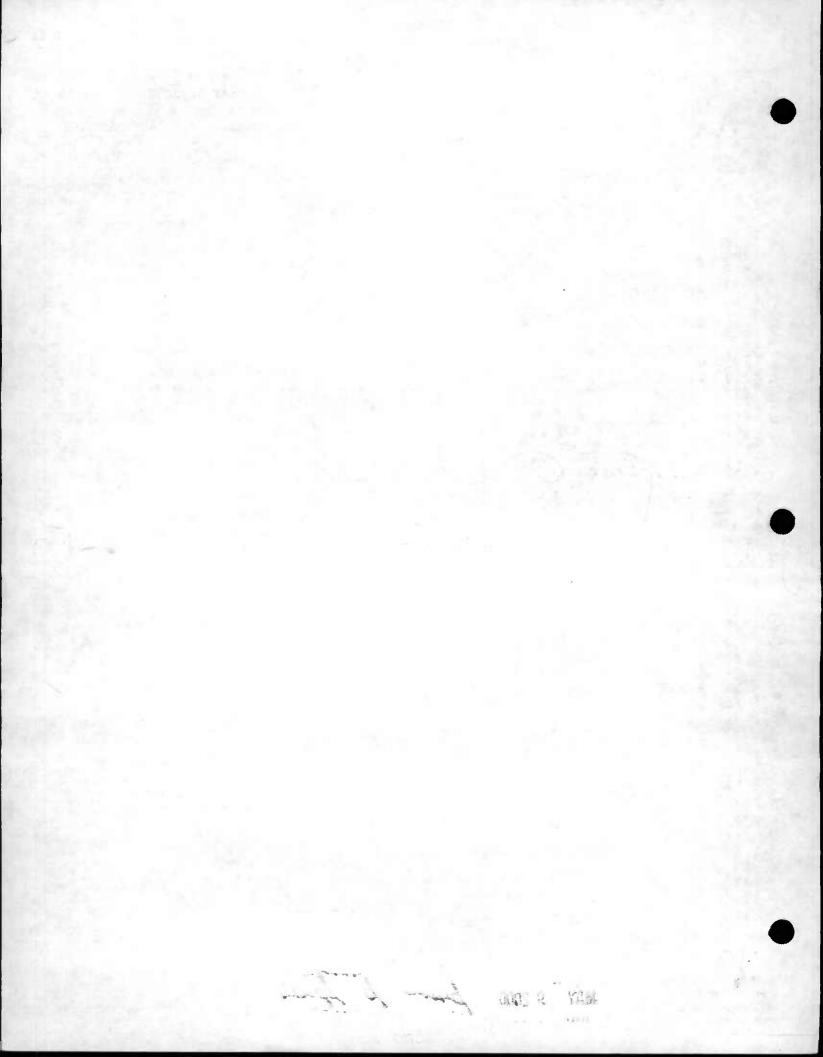
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State of Maryland / Department of Health and Mental Hygiene

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2 sho and is ma	19a. Informant's Name/Rela	ionship (Typ	oe, Print)		19b. Maili	ng Address	(Street	and Numb	er or Ru	ral Route Numb	er, City or Tow	n, State, Z	(ip Code)		
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or At Marco Direct in by	4 Homicide	termined	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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1	(m //	Jul				6	127	1782			May 5	120	00		
1	30. Name end address of pe	rson who cor	mpleted cause	of death (Item 23	3a) (Type,	, Print)	,			. 0	salt Ine			,	
V	Aron Be	ska	ran	2001	Sov	th H	uno	ver s	TH	eet 13	saltine	re. /	naryla	N	
State	31. Dete filed (Month, Day,	-		gistrar's Signature	0	6	A	00. 4		V					
Registrar	4	AY 9	2000>	Bear	ممر	P	P	west							
						7	-								



State of Maryland / Department of Health and Mental Hygiene 14860 Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Yee Month **Physician** Flora T. Liberto May 2000 10:00 a.m /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner N/A Baltimore 7007 Hamlet Avenue If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 6. Sex **Funeral** Sex 1 ☐ M 2 X F Months Deys Hours 85 220-07-3613 Maryland Director Jan. Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show man be notified at 1XXYes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21234 United States 7007 Hamlet Avenue Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. r than "naturel", or items the Medical Examiner ms 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Stetus Peges 1 end 2 should be filed within 72 hours after tent of Heelth end Mentel Hygiene.
Int: If Item 27 le marked other than "naturel", or the iry or other traumatic event, the Medical Examinary or other traumatic event, the Medical Examina 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 2 3 N Widowed 4 □ Divorced Be Completed 16e. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Packer Paper Company 6 yrs. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Maria Maranto Cimino Salvatore 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Reletionship (Type, Print) Annamaria R. Capella / Daughter 7007 Hamlet Avenue Baltimore, Maryland 21234 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removal from Stete permit. Pege Department o Important: If eny Injury or once. Baltimore, Maryland Most Holy Redeemer Cem. 5/10/2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee Michael Canapp 22. Name end Address of Fecility 5305 Harford Road Mia LEONARD J. RUCK, INC. 21214 Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical uew Examiner Due to (or es e consequença of) Examiner The lew requires that the death certificate be executed attending physician and for use es the burial-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that latted aware) Due to (or es e consequence of): Box 68760 Physician/Medical that initieted events resulting in deeth) Lest Due to (or es a consequence of) the 98 signed by the a d be detached f 23h Did tohacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by Division of Vital Records, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed hes 1 Yes 25 No 1 ☐ Yes 2 No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 25 No Certification: To this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred After 1 Neturel 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No after deeth. investigation 6 Could not be defermined Director 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funerel DI Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) DRIVE, BALTO, MYO 6830 HOSPICAL THA 31. Dete filed (Month, Dey, 32. Registrar's Signeture Registra

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Cer	tificate of	Death		Reg. No.		
1. Decedent's Name (First, Middla, I		The	)		2. Date of De	eath Day	3. Time of Death	
MARY MARY	LU	THEF	<		MAY		000 03.40 A	
niner 4a Facility Name (If not institution, g				4b. City, Town, or				
HARBOR HOS	SPITAL CEN	ITER		BALTII		N	/A	
	Sex 7. Age (In yrs	. lest birthday)	If Under 1 Year Months Days			th by, Year)	Birthplece (Stata or Forei Country)	
282 12 3473	80	Yrs.			Feb. 2		Ohio	
Usual Residenca of Decedent  10a. State 10b. County	100 0	ity, Town or Lo	nation				10d. Inside City Limi	
						1 ☐ Yes 2♥ N		
2	Arundel Ba	altimor	1					
10e. Street and Number			10f. Zip Coda	205		10g. Citizen of \		
5601 Liberty Te  11. Marital Status  1 Never Married 2 Married			212			U.S		
11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J,S. 13. V	Vas Decedent of I Yas, specify Cub	Hispanic Origin? (. ban, Mexican, Pue	Specify Yas or No to Rican, atc.)	- 14. Rac Blac	a - American Indian, ck, White, etc.	
The second secon	If Yes, Give	1	☐ Yes 2X No	Specify:		Specify	" White	
3 Widowed 4 □ Divorced	Year or Dates:					101 15 1 1 1		
15. Decedent's (Specify only highest of	Education prade completed)	16a. Daced	ant's Usual Occup kind of work done	pation during most of wo ed)	orking	16b. Kind of Bi	usinass/Industry	
15. Decedent's (Specify only highest generally Secondary (0-12) 12th	College (1-4or 5+)			)		Orm	Home	
12th 17. Fathar's Name (First, Middle, La:	nel	Homemaker 18 Moths			ma /First Middle		77.70710	
				18. Mother's Nama (First, Middla, Maidan Surneme)  Bertha (not available)				
	Henry Bussler				ertha			
19a. Informant's Name/Relationship			16	t and Number or F				
Claudia Emley	/ Daughter			ls Glen H			Maryland 212 City or Town, State	
20a. Method of Disposition 1 □ Burla1 2 ☑ Cremetion 3	Removal from State	cemetery, crem	sition (Neme of atory or other ple	eca)	Date			
4 Donation 5 Othar (Spec	city) Hi	11top S	Service (	Corp.	5/9/00	Towso	n, Maryland	
21. Signature of Funeral Service Lic	ensee	/ 22	. Nama and Addra	ass of Facility	Gonce I	uneral	Home P.A.	
( Lanne M	Znamiroush	2 40	01 Ritch	nie Highw	ay Balt	imore,	Md. 21225	
23a. Part 1. Enter the disease, or co shock, or haart failura. List on	mplications that coused the das						Approximata Interval Between	
SHOOK, OF HEART FAMILIE. ELST OF	ona causa on aach iina.						Onset and Death	
Immediata Causa (Final disaase or condition	METAB	BLIC	ACID	00515			3 days	
rasulting in death)	a	or as a conseq				4	, 0	
Sequentially list conditions,	RENAL		ILURE		0	nd	< 1 more	
Sequentially list conditions.	Dua to (	or as a conseq	uence of):				< Innone	
Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disaasa or injury that initiated evants	PANCR	EATI	c (	ANCE	?		6 month	
that initiated evants resulting in death) Last	Due to (	or as a consequ	uenca of):					
MV and M	0	- 7						
Part II. Other significant conditions	contributing to death but not re	sulting in the ur	derlying cause gi	iven in Part I.	23b. Did	tobacco usa co	ntributa to the causa of deat	
					1 🗆	Yes 2 No	3 Probably 4 Unknow	
						an autopsy ormed?	24b. Wara autopsy finding available prior to	
							completion of causa of death?	
					10	Yes 2 No	1□Yes 2□No	
25. Was case raferred to medical			111111111111	26. Placa of Dr	eath (Chack only	one)		
examiner?	Hospital: 1 EInpatient 20	☐ ER/Outpatien	t 3□ DOA Ot	hor.	Home 5 ☐ Ras		ner (Specify)	
27. Manner of Death	28a. Data of Injury	28b. Time of	28c. Inju			how injury occur		
1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	fnjury		ork? ]Yes 2 🗆 No	Section 1			
3 ☐ Suicide 6 ☐ Could not	be One Disea of trium. At I	nome, farm, str	et, factory, offica		28f. Location	(Street end Num l	ber or Rural Route Number,	
4 Homicide	building, etc. (Spec	ify)			City or To	iwn, State)		
27. Manngr of Death  1 DNatural 2 Accident investigat 3 Suicide 6 Could not datermine  29a. Certifier 1 Death	Physician: To the best of my kn	owledge death	occurred at the ti	ime data and plac	a and due to the	cause(s) and m	anner as stated.	
	aminer: On the basis of axamin and mannar stated.							
29b. Signature and vita of certifier	/		29c. Licen	se number		29d. Date signe	ed (Month, Dey, Year)	
11/10/	CHO - 14 Andle	rent 4-1	0	2110		MAU	2 2000	
	EVIDENT PHY			3140		1414	3,000	
	o complated cause of death (Ite	m 23a) (Type,	Print)	-0 ~	RAIT	10070-	MD 2122	
	DE MD, 300	1 5.	HANOVE	FR ST	DACI	WOLP !	111 414	
31. Data filed (Month, Day, Year)	32. Registrar's Sign	nature				-		
MAY S	2000	/	1 400	260				
				A .				

NAME OF THE PARTY

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician	1. Decedent's Neme (First, Middle, La	st)	Ce	rtificate c	n Death	2. Date of t	Reg. No.	3. Time of Death
		Josephine	Rose La	ang		Month May	Day	Year 7:10 P.M.
/Medical Examiner	4a Facility Neme (If not institution, giv			_	4b. City, To	wn, or Location of De		
	Genesis Elderc	are Hammonds	Lane		Balt:	imore	Anne	Arundel
Funeral	5. Sociel Security Number 6. S	DM WOTE	yrs. last birthday, Yrs.	Months Day		Min. (Month, I		Birthplace (State or Foreign Country)
Director	218 05 3585 Usuel Residence of Decedent	7	9 118.			Oct. 6	5, 1920	Maryland
WOT III	10a. Stete 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
ctor ctor	Maryland Anne Ar	undel	Baltimor	ce				1 ☐ Yes 2/☐ No
or 28	10e. Street and Number			10f. Zip Cod			10g. Citizen of V	Vhat Country?
eral	5203 - 4th Stree		-110 40	212		-:-0.40	U.S	
"natural", or frame 23e or 28e-f show refical Examiner must be notified at letted by Funeral Director	11. Maritel Stetus  1 Never Merried 2 Married  3X Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black,				e - American Indian, *, White, etc. White	
ted ted	15. Decedent's Ed		16a. Deca	dent's Usual Oc	cupation	ed weeking	16b. Kind of Bu	usiness/Industry
nt, me Medical to medical Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT use rel	tired)	or working		
Co F	8th		Hon	memaker	40.44.4	4-81		Home_
Be	17. Father's Name (First, Middle, Last)		Cohom			or's Name (First, Midd		10)
marke matic	19a. Informent's Neme/Reletionship (1	oseph Frank		ing Address (Str		Mary Krylo or or Rural Route Num		State Zin Code)
27 is r trau	William Lang	, , , , , , , , , , , , , , , , , , , ,		Arrowwo				ryland 21771
ant: If Item ury or othe	20e. Method of Disposition		b. Place of Disp	osition (Name of		Date		City or Town, State
וון וון וון וון וון וון וון וון וון וון	1 ☐ Buriel 2 🛣 Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify			Service		5/10/00	Towso	on, Maryland
Important: if item 27 is marked other than any Injury or other traumatic event, the Manages.  To Be Comp	21. Signature of Funeral Service Licen		1 2	2. Name and Ad	dress of Facilit	Gonce hway Bal	Funeral H	Home P.A.
	23a. Part1. Enter the diseese, of companies shock, or heart failure. List only	plications thet caused the o						Approximate
sician	Shock, or heart failure. List only	one cause on each line.						Intervel Between Onset end Death
edical miner	Immediate Ceuse (Final disease or condition	Chronic	Obstru	ctive	Pulmor	ary Dise	ease	12 years
	resulting in deeth)	0.	o (or es a conse					
nlne		b. Coronary			ase			8 years
buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due 1	o (or as e conse	quence of):				
ysicia ical	Cause (Disease or injury that initiated events	CDue t	o (or es e consec	aneuce ot).				
Wed the	resulting in death) Last	0301	0 (01 03 0 0011301	quarios orj.				
o by the attending principle of the state of		d						
ysic ysic	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause	given in Pert I	23b. Di	d tobacco use cor	ntribute to the cause of death?
Ph detec						N	Yes 2 No	3 Probably 4 Unknown
cate has been signed by the attending ph. page 2 should be deteched for use as th. Completed by Physician/Med							es an autopsy rformed?	24b. Were eutopsy findings aveilable prior to completion of cause
2 C							X-	of death?
rector, pag	25. Wes case referred to medical				OC Disease		Yes Ž No	1 Yes 2 No
	examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA	Other:	of Deeth (Check only		er (Snecify)
director O Be		28a. Dete of Injury (Month, Day Yea	28b. Time o	y 28c. Ir	njury at Work?	28d. Describ	e how injury occum	
e funerel direct atlon: To B	27. Manner of Death  1 ☑ Neturel 5 ☐ Pending  2 ☐ Accident investigation	1		reet fectory offic	Ce	28f. Location	(Street and Numb own, State)	er or Rural Route Number,
I Director: After this cent of in by the funerel direct certification: To Br	1 Neturel 5 ☐ Pending		At home, farm, st ecify)			City or 1	Own, State)	
be functed Director: After this cent pletely filled in by the funeral direct edical Certification: To Br	1 Neturel 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	28e. Plece of Injury - /	ecify) knowledge, deat	h occurred at the	e time, date an y opinion, dea	d place, and due to th	ne cause(s) and ma	unner as stated. and due to the cause(s)
al Director: After this led in by the funerel di	1 Neturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exam	28e. Plece of Injury - / building, etc. (Sp yelcian: To the best of my liner: On the basis of exam	ecify) knowledge, deat	th occurred at the	e time, date an ny opinion, dea ense number D141	d place, and due to the time	e cause(s) and ma e, date and place, a	d (Month, Day, Year)
To the Funeral Director: After this cent completely filled in by the funeral direct Medical Certification: To Br	1 Neturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier (check only one)  29b. Signature and title of certifier 30. Neme and address of person who of	28e. Piece of Injury - building, etc. (Sp. yalclan: To the best of my niner: On the basis of examend menner steted.	knowledge, deat	th occurred at the investigation, in m	ense number	d place, and due to the time	ne cause(s) and ma e, date and place, a 29d. Date signed	d (Month, Day, Year)
To the Funeral Director: After this cent completely filled in by the funeral direct direct Medical Certification: To Br	1 Neturel 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Piece of Injury - building, etc. (Sp. yelclan: To the best of my niner: On the basis of examend menner steted.	knowledge, deat innetion end/or in letem 23a) (Type, 0-A Rit	th occurred at the investigation, in m  29c. Lice	ense number D1 41	d place, and due to the time	te cause(s) and ma e, date and place, a 29d. Date signer 05/08	d (Month, Day, Year)

MA COLOR WAR

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				epartment of Health and It Certificate of Death		Reg. No.	14863
			1. Decedent's Name (First, Middle, Last)		2. Dete of Dec	eth	3. Time of Death
	Physicia		Clinton. LEAK		Month Max	Dey Yes 4 2000	
	/Medica Examine	_	4e Fecility Neme (If not institution, give street and number)	4b. City, Town, or L	May ocation of Deeth		
4	Examini		Genesis Eldercare Inalesi	do Balti	More	N	a
	Funeral		5. Social Security Number 6. Sex 7. Age (In yes, last birth	iday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	h 9.1	Birthplace (State or Foreign
	Director		231-10-6636 1EM 20 F 88 Y	rs. Months Days Hours Min,	0905		orth Carolina
	P .		Usuel Residence of Decedent		/		
	arylar thow		10a. State 10b. County 10c. City, Town	or Location			10d. tnside City Limits
	Maria .	Director	Md Na Bati	more			1 ☐ Yes 2 ☐ No
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	O Le	10e. Street and Number	10f. Zīp Code		10g. Citizen of What	Country?
	23a	<u>a</u>	3018 tairview Rd.	2/207		USA	
	ep L	Funeral	11. Menitel Status 12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Wes Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No-	14. Race - A Black, W	merican Indian, hite, etc.
20	or h	E	1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give	1 Yes 2 No Specify:			frican
8	ural	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:			A	nericun
21215-0020	filed within 72 hours efter deeth with the Meryland Hygiene. ther than "natural", or frems 23a or 28a-f show ent, the Mestical Examinal must be notified.	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of worl life. DO NOT use retired)	king	16b. Kind of Busine	ss/Industry
12	withir ene. than	E C	Elementary/Secondery (0-12) College (1-4or 5+)			insta	Cont
	be filed with ital Hygiene. d other than event, the		17. Fether's Neme (First, Middle, Last)	ong Shoreman	a (First Middle	Maiden Sumeme)	+ron1
an	S E S	o Be	11211 12-11	1			
2	should by nd Menta marked umatic ev	۴	19e. Informant's Name/Reletionship (Type, Print) (SOA) 19b.	Mailing Address (Street end Number or Ru	$aW_{111}$		70.0040
Maryland	0 0 0 0			. " [ ]	2/11	- 00 1	e, zip code)
a)	s 1 end f Health itsm 27 other tr	+		Disposition (Name of	Date	20c. Location - City	or Town State
Baltimore,	0 0		1 □ Buriel 2 □ Cremetion 3 □ Removel from State	, cremetory or other place)	~1.1	Ocal and	11/1/201
를		-	4 □ Donation 5 □ Other (Specify) □ GCT1		5/10/2000	DWINGS	, 141115, Md,
Ba	permit. Peg Department Important: If eny injury o		21. Signature of Funeral Service Licensee	22/ Name and Address of Facility	Frinera	al Home	) 10
			Joseph S. Russ	2222 W. North	Aue	Balto. 1	nd.21216
			23a. Pert1. Enter the disease, or complications that caused the deeth. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory er	rest,	Approximete Interval Between
	Physician						Onset end Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition a Myocardial resulting in death)	Infarction			One Day
		_	Due to (or es a co	onsequence of):			
	be tist	Examiner	b.				1
	ificete be executed g physicien and es the buriel-transit	хаг	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.	onsequence of):			
68760,	be e		cause. Enter Underlying Cause (Disease or injury				i
387	ficete p phys	edicai	that initieted events  Due to (or as a co	nsequence of):			1
×	ding se es		d				1
Box	attending	Physician/M	200		1 military sees		
P.O.	the de by the stached	ys	Part it. Other significant conditions contributing to death but not resulting in	the underlying cause given in Pert I.		22	ute to the cause of death?
9	es that igned b		Alzheimer's Dementia		10'	Yes 2 XNo 3	Probably 4 Unknown
of Vital Records,	The tew requires that the death certaine has been signed by the attendin page 2 should be detached for use	d by			24a. Was	en eutopsy 24	b. Were autopsy findings
Ö	v require been si should	ete	Benign Prostatic Hypertro	phy	perlo	rmed?	eveilable prior to completion of cause
3e	has ye 2	Completed				-	of death?
a					101	/es 2₹9 No	1 □ Yes ŽŽNo
7	Iclan: The certificate rector, page	Be	25. Wes case referred to medical examiner?  Hospital:	26. Place of Dea			
ot	hys hys	2	1 Inpatient 2 EH/Out	Authorit 3LI DOA 421 Nursing H		lence 6 Other (S	Specify)
	Attending Physician: or deeth. octor: After this certific by the funeral director,	Certification:	1 ⊠Netural 5 Pending (Month, Day Year) In	me of 28c. Injury et Work?  M 1 Yes 2 No	Zod. Describe i	low injury occurred	
Division	al or Attendir s after deeth.	Cal	2 Accident investigation 3 Suicide 6 Could not be 200 Place of Injury. At home for		20f Location (6	Proof and Number of	Rural Route Number,
N	or A sifter olin by		4 Homicide  determined  28e. Plece of Injury - At home, famouilding, etc. (Specify)	n, street, rectory, office	City or Tow		nural noute Number,
_	pital purs prel filled	<u> </u>	29a. Certifier 1 X Certifying Physicien: To the best of my knowledge.				
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by it	edicai	29a. Certifier (Check only one)  1 ★ Certifying Physicien: To the best of my knowledge, (Check only one)  1 ★ Certifying Physicien: To the best of my knowledge, one)  1 ★ Certifying Physicien: To the best of my knowledge, one of menner steled.				
	ithin o the or the	M M	29b. Signature and Mite/of certifier	29c. License number		29d. Date signed (Me	onth, Day, Year)
	F 3 F 8		1/16- Celling	D 30469			2000.
	11	-				.u.j Jell	2000.
,	0		30. Name and address of person who completed cause of death (Item 23a) (I		בוום	actt Cit	MD 21042
	Charles		N B Vellanki, MD; 9055, Chevr 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture	olet Drive, #100	L LIII	JOLE CIT	y, HD 21042
	State Registra	-		5 South			
			MAY 9 2000 Seneva	D BOOK			

MAN BEETH JOHN STEEL SAW

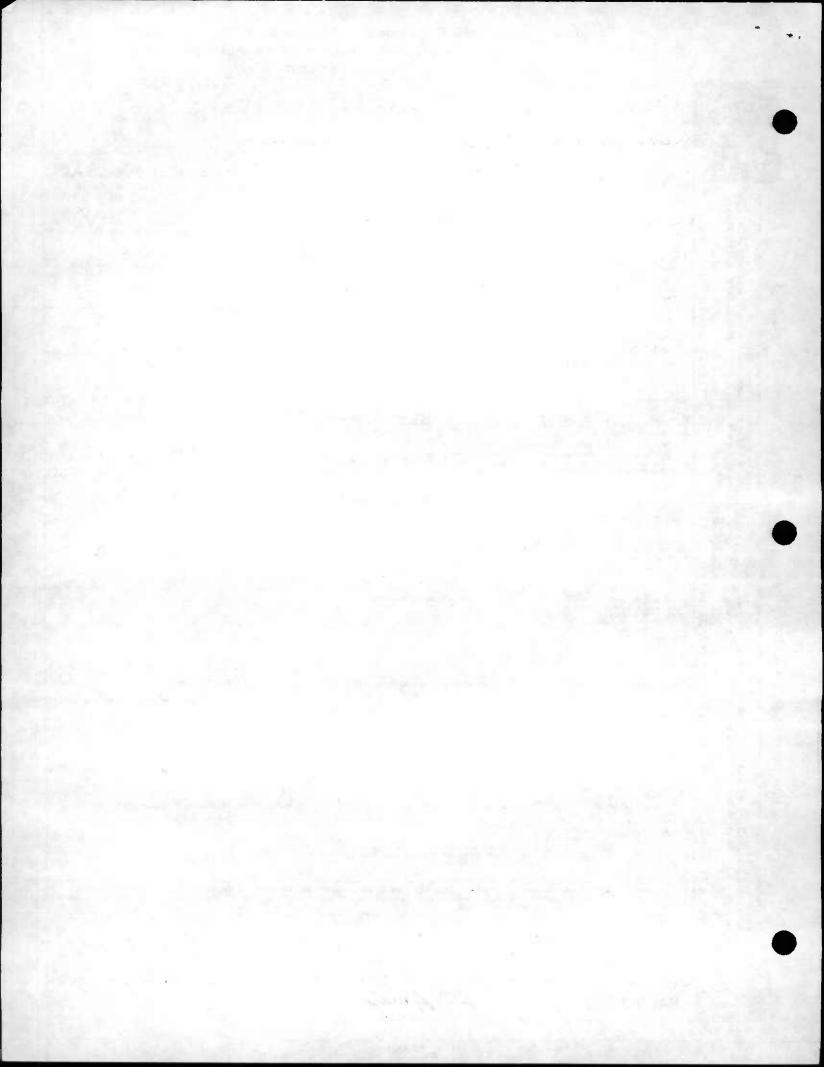
# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4864 Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev Month **Physician** 5, ARIZ ELIZABETH ALKO 12:30 A.M JAY 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BAYVIEW (ADICA) ATTIMORE If Under 24 Hrs. 8, Date SUIZI If Under 1 Yeer 9. Birthplece (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Min. Hours 1 M 28 F Yrs 118 Director 919 19 0800 1691,062706 Usuel Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Show 19€ Yes 2 No Funeral Director BALTIMORE 28a-f BURYEND 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number ò Raca - Amèrican Indien, Black, White, etc. 23a Bouldin STRZ 21224 1012 Rems ? 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca -11 Maritel Status filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Yes 250 No 21215-0020 ò Specify: WHIT 1 ☐ Yes 28 No Specify Completed by 35 Widowed 4 □ Divorced Year or Detes: natural 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry NEBIR i Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) OPERATOR 127RZ Movinb + STOREALE Baltimore, Maryland 18. Mother's Name (First, Middle, Malden Sumeme) 17. Fether's Neme (First, Middle, Last) . Pagas 1 and 2 should be fill mant of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be LATHERINE BOMHAROT CHARLIS Yound 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 31334 19e, Informent's Neme/Reletionship (Type, Print) MARYLAND PARKVILLE CHARLE F. EVANS, JA 8800 HARFORD KOAD 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition MAY 8 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Paga Departmant of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) CALTIMORE MARYLAND 2000 LAWN LEME LERY 21. Signature of Europeal Service Ligarnies 22. Name end Address of Fecility 46516 040 J.C MEMORIES 8800 HARFORD PRYLAD 23e. Pert1. Enter the disease, or complications to tracused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse sech line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) eizgszonu. Examiner Due to (or es e consequence of): Examine Tract Infection Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Box 68760. certificate be Physician/Medical Due to (or as e consequenca of) requires that the death P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 28 No of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed The law 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Certification: To Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No inpatient 2 ER/Outpetient 3 DOA 100 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Affac Division or Attending 5 Pending investigation 1 Neturel 1 Yes 2 No death. 2 Accident after death 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) and manner stated. 296 Signetage end little of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 98032 30. Name end address of person who completed cause of deeth (flem 23a) (Type, Print) SANGESTA .4940 EASTERN AVE. BALTIMORE MARVAND ARAMASI 32 Begistrer's

**DHMH 16 Rev 6/95** 

State Registrar MAY 0 9 2000



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. AMEND#9&19A PER INFMNT G783 5-22-2000 State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 1,8 per md G783 5/19/00 yg 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Edith Harner Kready Mellinger Month Year **Physician** 1:45 PN HARNER 3,9000 MELLINGER lau /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Franklin Square Hospital Center Rosedale | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 26,1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1□ M 20 F Yrs. 86 Director 203-07-1741 PENNSYLVANIA Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits **ehow** 1 Yas 2 No Director MD BAUTMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 BEDROCK CIP. U.S.A. Funeral 21236 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 □ Nevar Married 2 □ Married 1 Yes 2 No 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry al Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) 15 HOMEMAKER DOMESTIC Minger, pemit. Pagas 1 and 2 should be file Department of fealth and Mental Hyy Important: If Itam 27 is marked othe eny Injury or other treumatic event, pnce. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be F. KREADY BENTAMIN 2 HTICS F. HARNER 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) STEPHANIE M. HICKS DANGH HECK 2818 LOUISE AVE. BAUTIMORE MD. 21214 20b. Place of Disposition (Nama of cematary, crematory or other place)

ETANS FUNDAR CHAPEL 20c. Location - City or Town, State 20a. Mathod of Disposition MAY 5 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) FOREST HILL, MD 2000 BELAIR-P.A. 21. Signature of Funaral Service License 22. Nama and Address of Facility EVANS FUNDEAL CHAPEL 8800 HARFORD RD. PARKVILLE, MD. 21234 Mat caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, the on each line. 23a. Part. Entar the disaase, g shock, or heart failura. Approximata Intervel Between Onset end Death Physician /Medical Immediata Causa (Final disease or condition rasulting in death) Intlammatory Examiner Due to (or as a consequence of): Examiner Bacteremia The law requires that the death certificate be executed physician and as the burial-trans Sequentiatly list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Meningitis 68760. Physician/Medical Dua to (or as a consequence of) Box ( signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown Records, ğ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? s certificate has t 2 No 1 Yas 2 No 1 Yas Division of Vital or Attending Physician: 25. Was case refarred to medical Be 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Neturel 2 Accident 5 Pending invastigation e Hospital or Attending n 24 hours after death. e Funeral Director: Afti pietely filled in by the fun 1 Yas 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.
2 Medical Examiner: On the best of axamination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signatura end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19901 30. Nema and addrass of person who completed causa of death (Item 23a) (Type, Print) DrMaria 9000 Franklin Square Drive Baltimore, MD 21237 Greav 25 31. Date filed (Month, Day, Year) 32. Registrer's Signeture MAY 0 9 2000 Registrar

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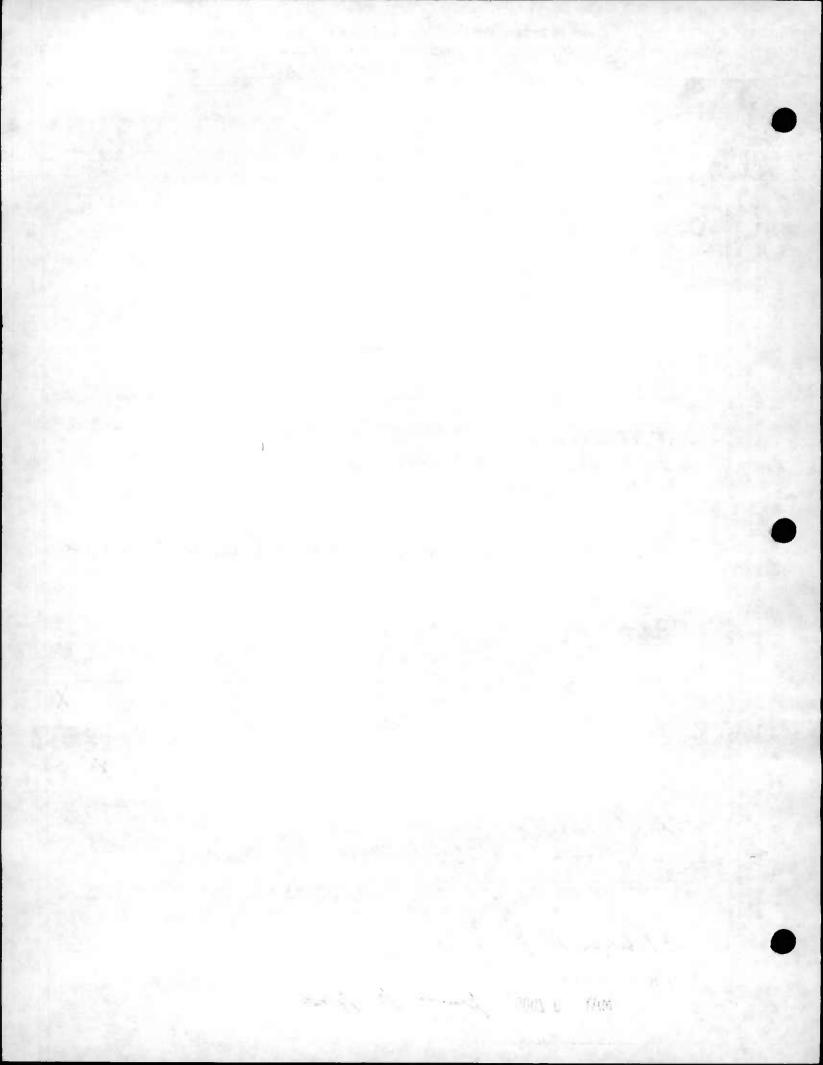
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	xander McKewen 16b PER FH G783 5/9/200	State of Ma		Certificate				Reg. No.		4866
	Decedent's Neme (First, Middle, Li						2. Date of Dea		Year	3. Time of Death
Physician /Medical Examiner	WILLIAM ALEXAND  4a Facility Name (If not institution, gir				4b. City,	Town, or Loc	May ation of Death	04	2000	7:20 A.M.
	Blenheim Road a	t Windy Far	ms Cour	+	Phe	onix		Balt	imore	2
Funeral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day) If Under 1	Year If Und	er 24 Hrs.	B. Date of Birt (Month, De	h	9. Birthp	lace (State or Foreign try)
Director	212-18-7199	1⊠M 2□F	80 Y	rs.			Nov 20,			land
and *	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					11	0d. Inside City Limits
within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Wedcal Examine must be notified at sympleted by Funeral Director	Maryland Paltimo	ra Country								1 ☐ Yes 21 No
or 28a-f a	Maryland Baltimon	te county	Pnoe	enix 10f. Zip C	ode			10g. Citizen of V	Vhat Coun	try?
		ivo			21131			TT	CA	
Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.	13. Was Decede		Origin? (Spec	ify Yes or No-	14. Rac	SA e - Americ	
		1 Tyes 2 No	0	1  Yes 2			ican, etc.)		k, White,	
d bv		Year or Dates:		100 20	Alto Speci	.,,.		Specify	Whi	re
Completed	15. Decedent's E (Specify only highest gr	ducation rade completed)	1	Decedent's Usual Give kind of work	done during m	ost of workin	9	16b. Kind of Bu	usiness/Ind	lustry
OW	Elementery/Secondary (0-12)	College (1-4or 5+	-77	life. DO NOT use	OWNER/PE	RESIDENI				SS COMPANY
S	12th 17. Falher's Name (First, Middle, Last	t)	1 Tile	memaker	18 Mot	ther's Name	(First, Middle	Own R Maiden Suman		rice
Be								a.c.s Juman		
To	William Alexande	er McKewen, (Type, Print)	Sr. 196. I	Mailing Address (	Street end Nun	MA ober or Rural	Route Number	eau er, City or Town.	State, Zip	Code)
	Kathleen Kane Mck									
	20a. Method of Disposition	zeweit	20b. Piece of I	Glenbro Disposition (Name crematory or oth	of	ve, rn	Oenix,	Maryla 20c. Location	City or To	wn, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci					i Indah !	10/200	)O m:	,	Maryland
	21. Signature of Funeral Service Lide	<u> </u>	Durane	22. Name and	Address of Fac	oility	0/0/2UL	O TIMOT	uum,	Maryland
	Markin OGSA	mom		Mitche:	ll-Wied	efeld	Funera	1 Home,	Inc.	
	Martin D. Law 23a. Part1. Enter the disease, or con shock, or heart failure. List only	VSON	the death. Do no	6500 You	ork Roa	d, Bal	timore	Maryl	and 2	1212 Approximete
Physician/Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (or as a co	onsequence of):	<i>y</i> 3 <i>9</i> 4 4 1		72,49	garly 1		
	Death Others In 18 and a state						I see Didd		4-11	
	Part II. Other significent conditions	contributing to death but	not resulting in t	me underlying cau	ise given in Pa	π (.		obacco use co Yes 2□ No	ntribute to 3 ☐ Prot	the cause of death?
								. Je 2LINO	0_7100	N OHAIOWII
							24a. Was perio	an autopsy med?	ava	ere eutopsy findings ailable prior to mpletion of cause death?
JIIIC							·H.	res 2□No	,6	Yes 2 No
Be Completed by	25. Was case referred to medical				DE DIA	ace of Death	(Check only o		1	2.00
ά o o	examiner? 1 ∑ Yes 2 □ No	Hospital:	t 2 ER/Outr	patient 3 DOA					er (Specifi	at scene
1100	27. Menner of Deeth  1.28 Natural 5 Pending (2 Accident investigation	28a. Date of Injury (Month, Day			c. Injury at Work?	2		now injury occur		,,
edical Certification:	3 Suicide 6 Could not be determined		ry - At home, fam (Specify)	n, sireef, factory,	offica	2	Bf. Location (S City or Tox		oer or Rura	Il Route Number,
S R S	(Check only 27 Medical Exa	hysicien: To the best of miner: On the basis of e	examination and/							
Med	29b. Signature and this of certifier	and manner stat	ed.	29c	License numbe	ar .		29d. Date signe	d (Month	Day Year)
	255 Signature of Continent	11.		250.	O.C.M			May 05		
	1 bear 1	1618	mo					-		
	30. Name and address of person who	completed cause of de	ath (Item 23a) (T							
	31. Date filed (Month, Day, Year)	32. Registrar	11]	Penn S	treet,	Balt:in	ore, M	aryland	2120	1
State egistrar	MAY 9		epera	PA	parks					
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 | 4867

				Certific	ale of	Deam			Reg. No.		
Physician	1. Decedent's Name (First, Middle Sophia Cecelia							Deta of De Month	eth Day	Year	3. Tima of Death 2:50 PM
/Medical Examiner	4a Facility Nama (If not institution Saint Josep				- 1	-	wn, or Locati		4c. County	of Death	imore
Funeral Director	5. Social Security Number 218-09-6631	6. Sex 1 □ M 2 💢 F	ige (In yrs. last bii 79	rthday) If Un Mont	der 1 Year hs Days	If Under Hours	24 Hrs. 8. Min. Se	Data of Bird (Month, Da 2pt.	<sup>th</sup> γ <sub>ear)</sub> 27, 1920	_Cour	olaca (State or Foraig otry) Cyland
fled at	Usual Rasidence of Decedent  10a. Stata 10b. County  Maryland N	/A	10c. City, Tow Balt	m or Location						1	0d. Inside City Limits
3a or 28a-fa at be notified al Director	10e. Street and Number 5937 The Alamed	a		10f.	Zip Code 21239	)			10g. Citizen of W		*
than "natural", or items 23s or 28s-f show he Madical Examiner must be notified at Impleted by Funeral Director	11. Marital Status  1 Never Married 2 Nam 3 Widowed 4 Divorced	If Yes Give	? [No		cedent of H specify Cubs	lispanic Ori an, Mexicar Specify:	gin? (Specify n, Puarto Rica	/ Yas or No an, atc.)	- 14. Race Black Specify:	k, Whita,	
Hydiene.  ther than "natural; of and, medical Exact  Completed by	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or		Decedent's U (Give kind of lifa. DO NO homema	work done	eation during mos d)	t of working		16b. Kind of Businass/Industry  OWN home		
end Mentel Hygiene. Is marked other than sumatic event, ms M. To Be Comp	17. Father's Nema (First, Middle, Vincent Mazersk	i				Mary	anna	a (First, Middle, Maiden Sumama) a (Unknown)			
Heelth ther tr	Joseph J. Marec  20a. Mathod of Disposition		59.	ace of Disposition (Name of Data 20c Location				MD 212	39		
nent o int: if	1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)  21. Signatura of Funaral Service Licensee  22. Nama and Address of Fecility Mitchell—Wiede									ltimore, Maryland	
Depenti Importa any Inji	1 Jalu 0. 1	netchell-	ZV.				6500 Y Baltin	York I nore,	Rd. MD 212		erai nome,
nysician Medical xaminer	Immediate Cause (Final disease or resulting in deeth)	complications that cause only one cause on each SEPSI:	3			ng, such as	cardiac or ra	spiratory a	rrast,		Approximate Interval Batween Onset end Death
n end iel-transit Examiner		RESPI	PATORY		-						
	Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a c								
Se se		d								1	
0 2 -	Part II. Other significant condition		but not resulting in	n the underlyin	g causa giv	en in Part I			Did tobacco use contribute to the cause of d		
s been s 2 should <b>pieted</b>									an eutopsy med?	ev.	are eutopsy findings allable prior to mplation of causa death?
certificate he rector, page	25. Was casa rafarred to medical axaminer?					26. Place	of Death (C	1□\		10	Yas 20 No
ter this neral di on: To	1 Yas 2 No  27. Menner of Death 1 Naturel 5 Pendin 2 Accident		ury 28b. 1	Tima of njury	DOA Oth  28c. Injun  Worl	4 LI NU	28d.		dance 6 Othe		y)
within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could r 4 Homicide determi	ined   28a. Place of it	njury - At home, fa dc. (Specify)	rm, street, fac	tory, office		28f.	Location (S City or Tox	Street and Number vn, Stata)	er or Rura	il Routa Number,
within 24 hours a To the Funeral completely filled Medical Co	29a. Certifiar (Check only one)	g Physician: To the best Examiner: On the basis of and manner s	of axamination and	, death occurr d/or investigat	ed et the tin ion, in my o	ne, date en pinion, dea	d place, end th occurred e	due to the at the time,	ceuse(s) end me date and place, a	nner es s ind due to	tated. o tha causa(s)
M ph	29b. Signature and the of certifier	20			29c. Licens				29d. Data signed		Day, Year)
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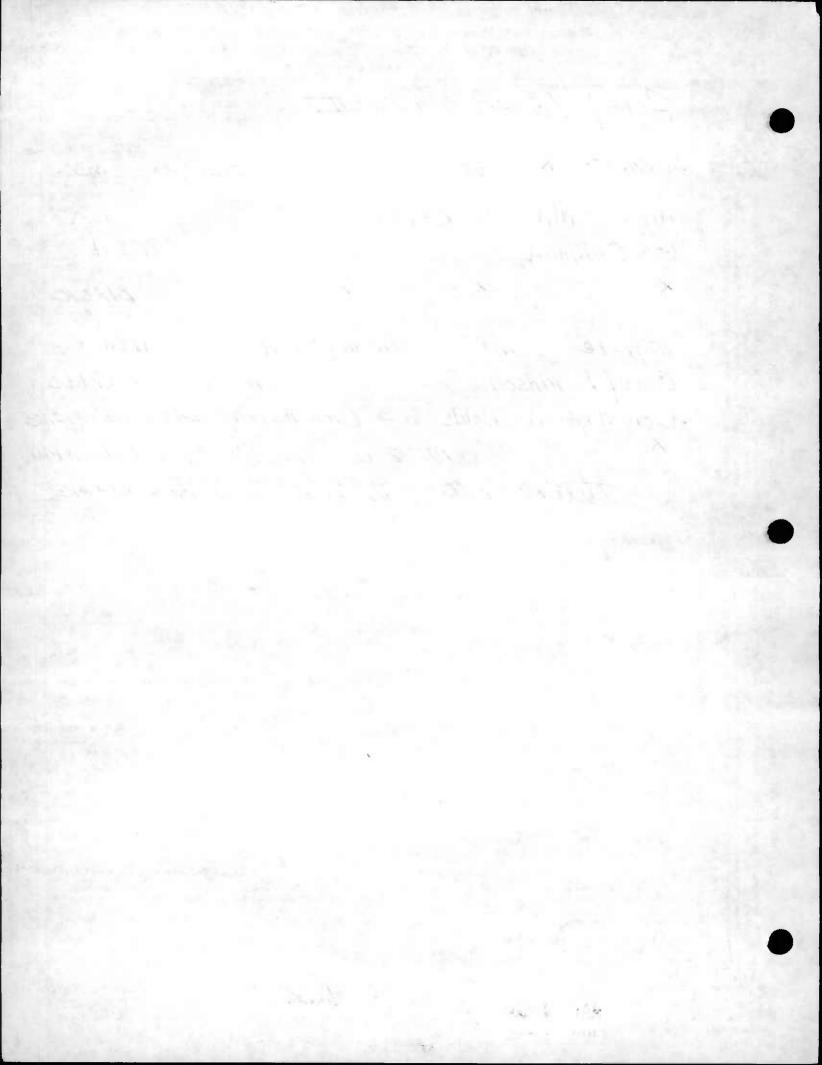
State of Maryland / Department of Health and Mental Hygiene

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			Certifica	ate of Death	Re	g. No.	
	1. Decedent'a Name (First, Middle, I	ast)			2. Date of Death Month		3. Time of Death
Physician /Medical	C'OREV /	AMAK 11	MASON,	71	May 04	2000	1331 pm
Examiner	4a Fecility Name (If not institution, g	ive street end number)	,,,,,		r Location of Death	4c. County of	Death
	Shock Trauma				imore	N/A	
eral		Sex 7. Age (In yrs	. lest birthdey) If Uni Yrs. Month	der 1 Yeer   If Under 24 H is Days Hours Mi	n. (Month, Dey,		Birthplace (State or Foreign Country)
tor	215-94-2492 Usual Residence of Decedent	20	115.		JAN.S	1980	mo ·
by Funeral Director	10a. State 10b. County	/ 10c. C	ity, Town or Location				10d. Inside City Limits
ó	mi Mi	A. I	3AHO.				1 Nes 2 No
Director	10e. Street and Number	1	101.	Zip Code	10	g. Citizen of Wh	af Country?
0	603 OAKIA	nd		212/2		21.	S.A.
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was De	cedent of Hispanic Origin? pecify Cuben, Mexican, Pur	(Specify Yes or No-		Americen Indian, White, etc.
	Never Married 2 Married			No Specify:	710 11021, 510.7	Specify:	Bla = B
Completed by	3 Widowed 4 Divorced	Year or Dates:				1	DIFICIO
ete	15. Decedent's (Specify only highest of	Education prede completed)	16a. Decedent's U	sual Occupetion work done during most of w Fuse retired)	orking 1	6b. Kind of Busi	ness/Industry
μ	Elementary/Secondary (0-12)	College (1-4or 5+)	Line	maladen	/	N.	on es
	17. Fether's Name (First, Middle, La.	st)	0,,,	18. Mother's N	ame (First, Middle, M	aiden Surneme)	
To Be	Carel 1.	MASON S	2,	1)19	roatha	De	Shields
-	44a. Informent's Name/Relationship	1100		ess (Street end Number or	Rurel Route Number,	City or Town, Si	tete, Zip Code)
	- DotCAThA	1) Shields	603	DAKLANG	AVE R	AH8.	md-212/3
	20a. Method of Disposition		Place of Disposition (/	Name of or other piece)	Date 2	Oc. Location - Ci	ity or Town, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		mt, 2:0	n CPM	5-11-200	LAnd	Edman MD.
d	21. Signature of Funeral Service Lic	ensee	22. Name	and Address of Facility	al volo	- P-	SCHOOL
oud	1 Talle	in bitt	112	on CARAL	RAI 140	SA HO.D	rd 212/3
	23a. Partt. Enter the disease, or co shock, or heart feilure. List on	implications that ceused the dec	ath. Do not enter the m	node of dying, such as card			Approximate the triterval Between
an	SHOOK, OF HEART ISHINES. LIST OF	y one cause on each line.					Onsef and Death
cal	Immediate Ceuse (Final disease or condition	. Monnie	& DWING	uiss			
ner	resulting In deeth)	Due to	(or as a consequence	of):			
Examine		b					
xan	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	of):			
	cause. Enter Underlying Cause (Disease or injury fhet initiated events	c					
edical	resulting in death) Last	Due fo (	or as e consequence o	f):			
2		d					
Cia	Part II. Other significant conditions	contributing to death but not re	eulting in the underlyin	a cause given in Part I	23b Did tol	acco usa contr	ribute to the causa of death?
Physician	. Sit in which eighthouse conditions	. 55. m. bomig to doctri but not re	soming in the dilutinging	g 55550 giron in Fait i.	1 Ye	_/	□ Probably 4 □ Unknown
by P					_		
					24a. Wes ar		24b. Were autopsy findings evailable prior to
Completed					- penon		completion of cause of deeth?
HO.	Efficient to				18 Ye	s 2 No	1 Yes 2□ No
Bec	25. Was cese referred to medical			26. Place of D	eath (Check only one	)	
To	examiner? 1½ Yes 2☐ No	Hospitel: 1 ☐ Inpatient 2	XER/Outpatient 3□	Other:	Home 5 Reside		(Specify)
	27. Menner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of	28c. Injury at Work?	28d. Describe ho		· I Yuuru
catio	20 Accident investigat	ion 5-4-00	1228 P M	1 Yes 2 No			w, IMPAU wo
Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc. (Spec	ify)	tory, office	City or Town	Stete)	or Rural Route Number,
		and	wy		Locureput	-	18 WOK BOUTHING M
edical	(Check only 2/7 Medical Ex	hysician: To the best of my kn milner: On the basis of examin	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death o	ce, and due to the ce curred et the time, da	use(s) end ment te and place, an	ner as stated. Indicate to the cause(s)
Med	ura)	and manner stated.		29c. License number			(Month, Day, Year)
	29b. Signature end fitte of certifier	11/100		O.C.M.E.		May 05,	
4	Mulmine 10	me shall				2 00,	
2	Name and addiess of person when MARLA MOD D	1.4					
	7.31-1	. Whore em	11	1 Penn Street	t, Baltimo	re, Mary	yland 21201
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	nature &	Sports			

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# ath leen memillen

		1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physiciar	Kathleen Kelland McMillon			Month 4 Dey 2	000 7:40 A.M.
	/Medica Examine	As Facility Name (Many Institution of the Asset Institution of the Asse		4b. City, Town, or Loca	7 /	nty of Deeth
d	Examinic	Franklin Square Hospit	tal center	Roseda	le Bo	Himore
	Funeral	5. Social Security Number 6. Sex 7. Age (In )	yrs. lest birthday) If Under 1		3. Date of Birth (Month, Dey, Year)	9 Birthplace (State or Foreign
г	Director	236-32-6284 1 M 2 MF 7	75 Yrs. Months	Deys Hours Min.	(Month, Dey, Year) 19/29/1924	Country) WV.
		Usuel Residence of Decedent			., ., ., ., .,	
	how how		. City, Town or Location			10d. Inside City Limits
	o Me	MD. Baltimore	Essex			1 □ Yes 25 No
	4 to 2 do 2 do 2 do 2 do 2 do 2 do 2 do 2	10e. Street and Number	10f. Zip (		10g. Citizen o	of Whet Country?
	ifter death with the Maryler of terms 23s or 23s-f show there must be notified at Finners! Director	10215 Bird River Rd.	2	1220	USA	
	ours after deared; or items	11. Maritel Status 12. Was Decedent Ever in Armed Forces?	in U,S. 13. Wes Decede	nt ot Hispanic Origin? (Spec y Cuban, Mexicen, Puerto R	ify Yes or No-	Raca - American Indien, Bleck, White, etc.
2	afte of H		1 ☐ Yes 21	4	Spec	
Š	ureli, o	Year or Detes:			Эре.	white
0200-91212	led within 72 hours after death with the Maryland bygiene.  Yethan 'naturel', or itema 23a or 28a-f show It, the Medical Examine must be notified at Commissed by Firmses! Director	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual (Give kind of work	Occupation done during most of working retired)	16b. Kind of	Business/Industry
7	han han	Elementery/Secondary (0-12) College (1-4or 5+)				ectronics
	Digital C	12 17. Fether's Neme (First, Middle, Last)	Assembly	Line Worker		
Ě	D S D D	Harry Walter Kum			First, Middle, Meiden Sum Washington	өтө)
Ž	should nd Man marke umatic					
Maryland	le n	19e. Informent's Name/Relationship (Type, Print) Hilda Vetter Daughter	19b. Mailing Address (	Street end Number or Rurel	Route Number, City or Tow altimore, MD	
	lealt m 27		Db. Plece of Disposition (Neme			
Ö	Peges nent of h int: if he iry or of	1 ■ Burial 2 □ Cremetion 3 □ Removel trom State	cemetery, cremetory or oth	er plece)		on - City or Town, State
	Ement thent tant: I		licholson Chap		/08 Morgan	town, WV.
saitimore,	permit. F Depertme Importan any injur	21. Signature of Funeral Service Licenses		Address of Facility  Research Schw	ah Funeral H	ome Inc.
	707 e a	Comand Calina		ondson Ave. B		
		23a. Pert1. Enter the disease, or complications that ceused the d shock, or heart teilure. List only one ceuse on each line.	deeth. Do not enter the mode	ot dying, such es cardiac or	respiretory errest,	Approximate Intervel Between
	Physician	17				Onset and Death
	/Medical	Immediate Ceuse (Finel disease or condition Metas-	tatic Lu	ou Canc.	0 –	lyear
	Examiner	Due t	to (or es a consequence of):	- Corne		
	executed in and itelitransit					
	death certificate be executed ettending physicien and of or use es the burlet-transit stellan/Medical Examin	Sequentially list conditions, Due to	to (or es e consequence ot):			
Š	se ex					
09/90	eath certificate be ettending physici for use es the bu	that initieted events resulting in death) Lest	o (or es e consequence ot):			
	ling p					
gox	tend or us	<u>.</u>				
5	e de the e hed the hed to	Pert II. Other significant conditions contributing to death but not	resulting in the underlying cau	ise given in Pert I.	23b. Dtd tobacco use	contributa to the cause of death?
Z.	The lew requires that the de sate has been signed by the c page 2 should be detached Completed by Physic	Chronic Obstructi	in Oulm	00001	1□Yes 2XNo	3 Probably 4 Unknown
ń	the series of	CHIOME O'ST GET	100 Parm	011009		
cords,	equiling	Disease, Congestive	e Heart F	Eilare	24a. Wes en eutopsy performed?	24b. Were eutopsy tindings aveileble prior to
	2 2 0	3132432 / -011763 /110	77247	011010		completion of cause of death?
	The page	Colonic Obstruction			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
2	tending Physicien: The lew eath. or: After this certificate has the funeral director, page 2.			26. Place of Deeth (	Check only one)	
2	Physicien: this certific ral director,	Hospitel:	2 ER/Outpetient 3 DOA	Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ C	Other (Specify)
0	d Ph	27. Menner of Deeth 28e. Dete of Injury 1 N Naturel 5 Pending (Month, Dey Year	r) 28b. Time of 28c	Unjury et 28 Work?	d. Describe how injury occ	berruc
VISION	Attending in deeth. After the fune by the fune life at long.	2 Accident investigation	M	1 ☐ Yes 2 ☐ No		
5	ar de by ti	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	At home, farm, street, factory,	office 28	Rt. Location (Street end Nur City or Town, Stete)	mber or Rural Route Number,
5	tal or Attending P rs after deeth. al Director: After t led in by the funera Certification:	bollang, sto. (ep.	oony			
	ne Hospit n 24 hours se Funer pletely fill		knowledge, deeth occurred et	the time, dete end plece, en	d due to the ceuse(s) end	menner es stated.
				ing opinon, death occurred	or the time, dete end piec	o, and due to the ceuse(s)
	To with	29b. Signature end title of certifier	29c.	License number	29d. Date sign	ned (Month, Day, Year)
	200	Mares of Laure	-100	D40819	May	4 2000
10	26	30. Name end eddress of person who campleted cause of deeth (I				1, 2, 2
X	0)	Dr. Marco Zamora 9000	Franklin Sa	yare Drive	Baltimore	, MD. 2123)
	State	31. Dete tiled (Month, Pay, Year) 2000 32. Registrer's St				
	Donish	a diameter	17 1	. /		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14869

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14870

				Cei	tificate o	f Death	ר		Reg. No.		
Physician	1. Decedent's Nama (First, Middle	a, Last)						2. Deta of De Month	ath Day	Yaar	3. Tima ol Death
/Medical	Herman	Meeks	200					5	2 2	000	11:26
Examiner	4a Facility Nama (If not institutio				g 11-4-4 V-	Bo	altin		N/A		
Funeral Director	5. Social Sacurity Number 215-30-2420 Usual Residence of Decedent	6. Sax 1)∑ M 2 □ F	7. Aga (In yrs. last	Yrs.	If Undar 1 Yas Months Day		Min.	8. Data of Bir (Month, Da	iy, Yaar)	Coui	placa (Stata or Foraign ntry) sylvania
with the Maryland a or 28a-f show be notified at	10a. Stata 10b. County MD N/A		10c. City, T		cation						10d. Insida City Limits 1√□ Yas 2□ No
23e or 28 unit be not	10e. Street and Number 325 S. Stricke	r Street			10f. Zip Code 212				10g. Citizan of What Country?  USA		
or home	11. Marital Status  1 Nevar Marriad 2 Mar  3 1 Widowed 4 Divorced	ied 1 Yas 3	No No		Vas Decedant of Yas, specify Co			ecify Yas or No Rican, atc.)	14. Race - Amarican Indian, Black, Whita, atc. Specify: White		atc.
c 1 8 -	15. Decedar (Specify only higha	t's Education st grada complated)	1	(Giva	tent's Usual Occ kind of work dor OO NOT usa reti	a duning mo	ost of work	king 16b. Kind of Businass		usinass/In	dustry
Hygiena.  Hygiena.  Ther than "r  mit, m. Nec.	Elamantary/Secondary (0-12) 7	Collega (1-	4or 5+)	Tru	ck Drive	/er 18. Mothar's Nama (First, Middla, Ma				sport	ing
igns a fair a short or lied within to Health and Mantal Hygiene. If item 27 is marked other than or other traumatic event, me. M.  To Be Comp.	17. Fathar's Nama (First, Middla, Herman Meeks				Tag.		nars Nami	a (First, Middia	, Malgan Sumer	ne)	
	19a. Informant's Name/Reletions Carol Caviness				ng Addrass (Stre						Coda)
pemit. Pages 1 and 2 Department of Health of Important: If Item 27 is any injury or other tra phos.	Carol Caviness - daughter  20a. Mathod ol Disposition 1 D'Burial 2 Cramation 3 Cambridge Street, Baltimore, 20b. Plece ol Disposition (Name of cematary, cramatory or other place) 4 Donation 5 Other (Specify)  20b. Plece ol Disposition (Name of cematary, cramatory or other place) Loudon Park Cemetery								20c Location - City of Town State		
permit. Pa Departmar Important: any injury once.	21. Signatura of Funaral Sarvice	Licensee	e/Moio	Ga	Nama and Add ry L. Ka 50 Wash:	aufman	Fune	eral Ho	me @ Mead	dowri	dge MP, Inc
See street be executed find physician and find physician and sees the buriel-transit sees the buriel-transit and find physician	Immediata Ceuse (Finel disaasa or condition rasulting in death)  Sequentially list conditions, if any, leeding to immediata cause. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last	8 b	Due to (or as	s a/consec	uence ol):	Di	5668 (				
the death of the attentached for untached fo	Part II. Other significant condition	ons contributing to dea	ath but not rasultin	ng in tha u	ndarfying causa	given in Par	t I.		tobacco usa co	ontribute t	o the causa of death
2 Pg 2			ķ						an autopsy ormad?	av	ere autopsy findings vailabla prior to emplation of cause
The law page 2	25. Was casa ralarred to medica		1			ne Plo	en al Dani	1 Check only	Yas 2 No		daath? ☐ Yes 2☐No
Physician: this carific ral director. TO Be (	axaminer?	Hospital:	patiant 2 ER	/Outpatier	t 3D DOA	Other:			Idanca 6 Oti	har (Speci	(v)
ng Ph ther th uneral	27. Menner of Death  1 Natural 5 Pandir 2 Accidant invasti	28a. Data of (Month		b. Tima o	28c. In	jury at /ork? ☐ Yes 2 [			how injury occu		
To the Hospital or Attending P within 24 hours effect death. To the Funeral Director. After completely filled in by the funeral Medical Certification:	3 Suicida 6 Could datarm	ined 288. Placa	ol Injury - At homa g, atc. (Specify)	ı, farm, str	eet, factory, office	e		28f. Location ( City or To	(Street and Num wn, Stata)	bar or Run	al Routa Number,
ne Hospital no 24 hours ne Funeral pletely filled		g Physician: To the b Examiner: On the bas and mann	sis of axamination								
To the comple	295. Signature and title of capifie		ms	>	29c. Lica	nsa number	318		29d. Data signo	2/0	Day, Year)
	30. Nama and addrass of person	who complated causa	of death (Item 23	Ba) (Type,	Print)				C CHEC		
State Registrar	MAY 9 2	100 32 Ro	gistrar's Signature	6	hort						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath Day Month Yaar **Physician** 30 2000 MAY 01 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE THORNFIELD OAD If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) (Month, Day, Yaar) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Days 10 M 2 F 218 -52-4688 3 Yrs. VIRGINIA Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r 25a-f show 1 XYas 2 No Director MARYLAND 10f. Zip Coda 196. Citizan of What Country? 10e. Street and Number must be n 523 HORN FIELD KOAD USA. Funeral Was Dacedent Ever in U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yas 2 No If Yas, Giva Yeer or Detas: 1 Nevar Married 2 Merried ò Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. ğ BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry I Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) SPECIALIST CARR LOWERY GLASS CA OTHGRADE 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) Be is marked or ACKSON ESTELLE SNYDOR 10 HERMAN 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Reletionship (Type, Print) Department of Health a important: if them 27 is any injury or other tras THORN FIELD ROAD, BALTIHORE, MD. 21229

tion (Nema of Data 20c. Location - City or Town, Stata MIL (DAUGHTER OHNA 20b. Placa of Disposition (Nema of cematary, crametory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) MEHORIAL PARK 05-06-00 WOODLAWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility BROWN JR. FUNERAL HOME JOSEPH 2140N. FULTON AVE. BALTO. MO. 23e. Rert1. Enter the disaasa, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or raspiratory er shock, or haart failura. List only ona causa on each line. Approximate Interval Batwaen Onsat and Death Physician /Medical Immediate Ceuse (Finel disease or condition rasulting in daath) Examiner Examiner The law requires that the death certificate be executed bunial-transit Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last Box 68760 Physician/Medical Dua to (or as a consequenca of) esn. ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed 1 Yas 2,2 No 1 □ Yas 2 □ No of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of injury 28c. Injury at Work? 28d. Dascribe how injury occurred After Division or Attending 5 Panding invastigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be determined 28f. Location (Street and Numbar or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Thomicida Certifying Physician: To the best of my knowledga, daath occurred et tha time, data and piace, end due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at tha tima, date and placa, and due to the cause(s) end mannar stated. edical 29a. Certifier (Check only one) 29b. Signatury and title of certific 29c. Licansa number 29d. Data signad (Month, Day, Year) eled cause of death (Itam 23a) (Type, Print) 30. Nama and addrass of person 31. Data filed (Month, Day, Year) 32. Registrar Signatura State

DHMH 16 Rev 6/95

Registrar

MAY 0 9 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 3. Time of the 2. Data of Death Month **Physician** Naomi Grace McLaughlin MAY 7 11:30AM 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Deaton Speciality Hospital and Home Inc. N/A Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 2 LF 213-26-7223 73 Director Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at 1 ☐ Yas 2 ♥ No Director Maryland Harkord Joppa 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21085 1212 Joppa Road U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Yes 2 ☑ No tf Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Ď Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry el Hygiene. Elemantary/Secondary (0-12) Coltega (1-4or 5+) Homemaker Own Home 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h end Mentel F Mable Alice Asher Amos Z. Cheek 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health er Important: if item 27 is any Injury or other trau 1212 Joppa Road, Joppa, Md 21085 Clarence W. McLaughlin (Husband) 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Ramoval from State 5/8/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) Gardens Of Faith Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Betwaan Onset and Death Physician Immediate Cause (Finat disease or condition rasulting in death) /Medical septicemia a days Examiner Dua to (or as a consaquanca of) Physician/Medical Examiner preumoni a the burial-trensit executed Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last pue Due to (or as e consequence of): 4 monts Levilura road! ettending physician The law requires that the death certificate be Due to (or as a consequence of): for use es P.0. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. be deteched 23b. Did tobacco use contribute to the cause of death? Kulune rennlator þ Respiratory dependent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Wara autopsy findings evelleble prior to completion of cause of daath? page 2 should Completed anoxic encorhalenation 24a. Was an autopsy certificete has been 1 Yas 2 Ko 1 ☐ Yes 2 No of Vital or Attending Physician: Be 25. Was cese raferred to medical 26. Place of Death (Check only ona) axaminer? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No After this filled in by the funerel 27. Manner of Daath 1 Naturat 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred Division 5 Panding investigation To the Hospital or Attending within 24 hours effer death. To the Funaral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Coutd not ba determined 3 Suicida 28f. Location (Streat and Numbar or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and placa, and dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner statad. 29a. Certifier Medical 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 030494 515/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Mistim Beatin Invalice | Conter 611 south chanles street Baltimore modifies 31. Dete fited (May Yay, Yeg) 32. Registrar's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Yaar **Physician** Barbara Anne Martin 2000 2:00 p.m. May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Lutherville Baltimore Brightwood If Under 1 Year Birthpleca (Steta or Foraign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year)
Nov. 29, 1 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2K F Yrs. 61 1938 Director New York 212-34-1335 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or 28a-f show ed other than "naturel", or flems 23a or 28a-f shows svent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Arbutus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1119 Circle Drive 21227 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien. 11. Marital Status Black, Whita, etc. e filed within 72 hours after of Hyglene.
other than "naturel; or he 1 Yas 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) Collega (1-4or 5+) Entertainment 11 0 Entertainer permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if item 27 is marked other eny injury or other treumatic svent, other. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Virginia Paulson Unknown 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 4701 West Parker Road Suite 612 Plano, Texas 75093 Shane D. Salinas/ Daughter 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5/3/ 2000 Catonsville, Maryland 21. Signature of Funaral Service Licensed 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Lung Cancer Immediata Causa (Final disaasa or condition rasulting in daath) Examiner The law requires that the death certificete be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or injury that initiated evants rasulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 1 Yes 2 No 3 Probably 4 → Onknown Division of Vital Records, þ 24b. Wara autopsy findings available prior fo Completed 24a. Was an autopsy performed? completion of cause of death? Acciden 1 Yes 2 No 1 Tes 2 1 No Oreho vascular 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 10 his 28a. Data of Injury (Month, Day Year) 27. Mannacof Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 (Naturel or Attending 5 Pending invastigation death. 1 Yas 2 No 2 Accident Director: 6 Could not be 28f. Location (Straet and Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) after 4 | Homicida To the Hospital or within 24 hours aff To the Funeral Di completely filled in edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steled.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e, Cartifier (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and fitla of certifier

Registrar

**DHMH 16 Rev 6/95** 

Shalani Tewari

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30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

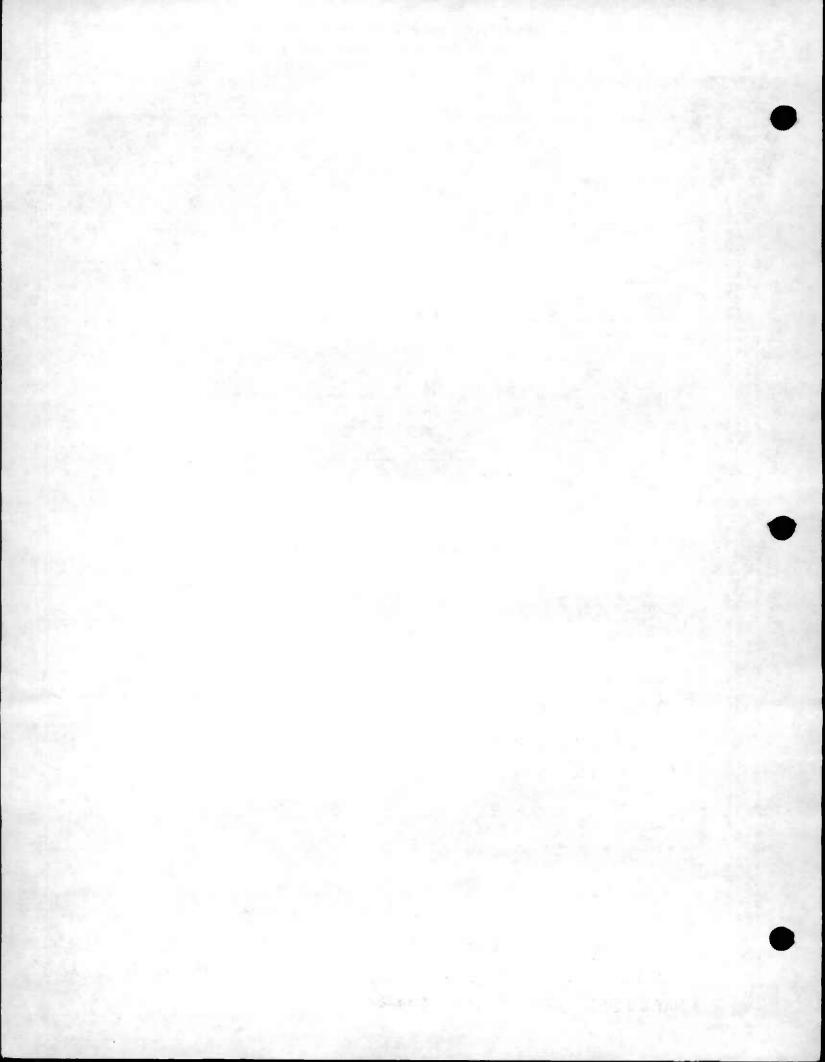
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31. Data filed (Month, Day, Year)

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32. Registrar Signatura



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Year **Physician** 3.02 PM Stanley L. Mills 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Burnie ANNE ARUNDEL Alundel HOSpita GIEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1MM 2□ F Yrs 577-14-3177 78 Director May 20, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hama 23s or 28s-f show idical Examiner must be notified at 1 Yas 2♥ No Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 Pittsfield Lane 20716 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or its 1⊠Yes 2□NeWWII If Yes, Give WWII Year or Dates: Korea 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Electrical Engineer Vending 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 89 Wilmer Mills Julia Sterling 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Donna R. Mills-Flippo (Daughter) important: If Item 27 any Injury or other tr 1606 Pittsfield Lane, Bowie, MD 20716 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a, Method of Disposition 05/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 2000 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. nature of Funeral Service Lic ITULA 12 Ridgely Avenue, Annapolis, MD 21401 Approximata Intarval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician SEPTICE MIA. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ettending physicien end for use as the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): signed by the eld be deteched f Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use/contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Ware eutopsy lindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? has 1 Tes 2 NO 1 ☐ Yes 2 ☐ No this certificata Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completaly filled in by the funeral director, 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To NZ Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and menner as stated. edical 29a. Certifier (Check only one) 2 Medical Exa iner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 0 9 2000

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32. Registrar's Signatu

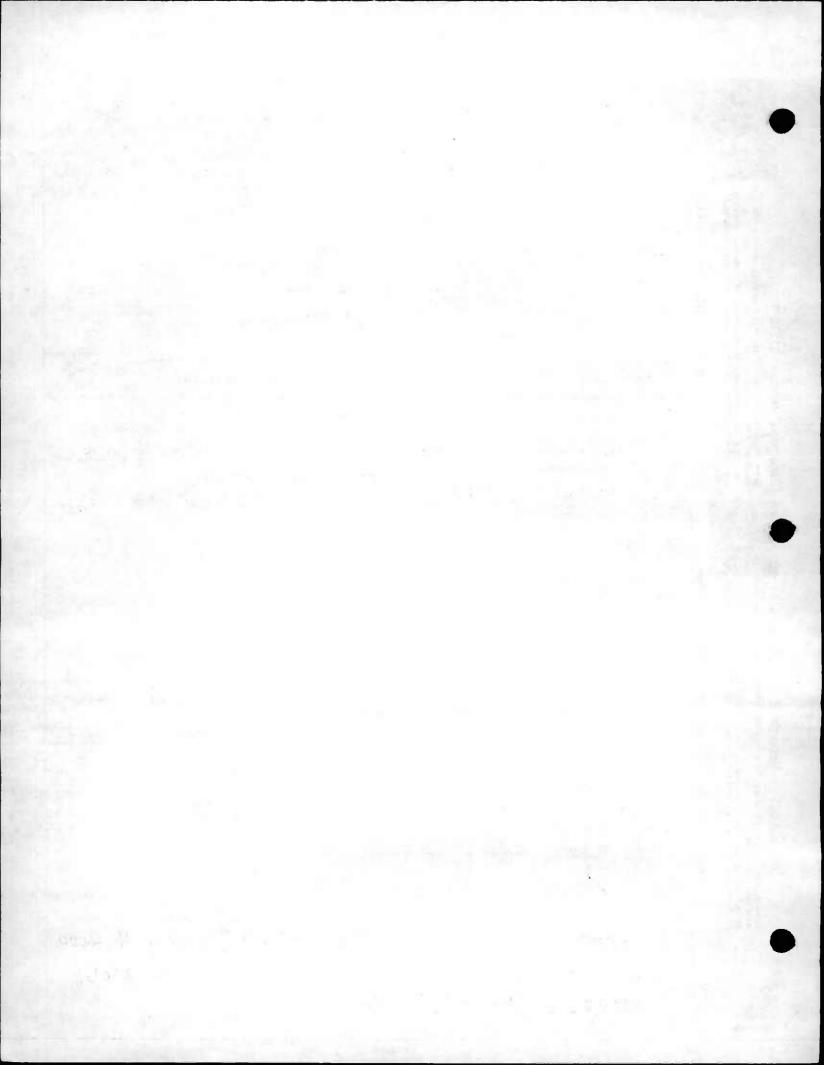
301 Hospital

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

len Eneroi.

29d. Data signed (Month, Day, Year)



## Please Type or Print In Black Indeilble Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4875 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Melvin W. Moyer May 2000 6 8:00 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gensis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 26, 1918 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplaca (Stete or Foreign Country) **Funeral** Months Days 1XM 2□ F 166 18 4508 Yrs. Director Pennsylvania Usuel Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes ZX No Maryland Anne Arundel Linthicum Heights Director 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 203 Exeter Court 21090 238 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2월 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Merital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ò Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) 12 College (1-4or 5+) Hand Printer Compositor 1 year Government Printing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental h William M. Moyer Sarah Frantz 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of Health : Hem 27 b Carolyn Moyer 203 Exeter Court Linthicum Heights, Md. 21090 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its any Injury or off 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Cedar Hill Cemetery 5/10/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. manualla 4001 Ritchie Highway Baltimore, Md. 21225 23e. Part. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Final diseese or condition resulting in deeth) MULTIPLE ORGAN SYSTEM FAILURE /Medical 2 WEEKS Examiner Due to (or es e consequence of): MANY Physician/Medical Examiner PARKINSONS DISEASE YEARS The lew requires that the death certificate be executed burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): MANY CORONARY YEMOS Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ Be Completed 24b. Were eutopsy findings aveilable prior to 24a. Wes an autopsy completion of cause of death? 2 No 1 ☐ Yes 3 ☐ No this certificate Division of Vital Attending Physician: director, 25. Wes case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 funeral 27. Manner of Deeth 28c. Injury at Work? Certification: 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 Yes 2 No investigation 2 Accident after death Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medical 29c. License number 29d. Date signed (Month, Day, Year) 125807 CARLOS D. ZIGEL, 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) SOUTH CRAIN AWY. #106 GLEN BURNIE Registrar

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## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Depart

partment of Health and Mental Hygie	ene	$\cap$	N
ertificate of Death	No	V	V

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		Ce	milicate of I	Death		Reg. No.			
1. Decedent's Name (First, Middle, Last) DENUER	P.	Ma		SR.	MAY	02 2	Yaar 9:53 pm.		
HARBOR HOSPIT	TAL CEN	TER		BALTI	MORE	BAL	TI MORE CITY  9. Birthplaca (Stata or Foreign		
219 03 9298		Yrs.	Months Days		Nov. 22	y, Year) 2, 1922	Country) Maryland		
10a. State 10b. County		•					10d. Inside City Limits 1 ☐ Yes 2★ No		
10e. Street and Number 682 Chestnut Sprin	ngs Lane		10f. Zip Code 2106	60					
11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in L Armed Forcas? 1X Yes 2 □ No If Yes, Give Year or Dates: W • W •	II 13.			Specify Yes or No to Rican, etc.)	Blac	e - American Indian, ck, White, etc. White		
15. Decedent's Educe (Specify only highest grade	ition com <i>pleted)</i>	16a. Deca	dent's Usual Occup	eation during most of wo	16b. Kind of Business/Industry				
Elementary/Secondary (0-12)	College (1-4or 5+)			d)		Greyhound			
17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middla	, Maiden Sumam	a)		
Mar	shall McCab	9		D	aisy DeV	Vitt			
19a. Informant's Name/Ralationship (Type Winona McCabe /	wife								
20a. Method of Disposition 1   □ Burial 2 □ Cremation 3 □ Real 1 □ Donation 5 □ Other (Specify)	noval from Stata				Date 5/6/00		City or Town, State  Alta, W.V.		
21. Signature of Funeral Service Licensee	ramerolis	1-					Home P.A. Md. 21225		
Immediate Causa (Final disasse or condition	. /					rrast,	Approximata Intarval Batween Onset and Death		
rasulting in death) a.	Dua to (	or as a conse	quence ot):				45 minute		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last	CORONA	or as a consa	quence of): ARTERY	Dise	ASE		20 years		
Part II. Other eignificant conditions contr	ibuting to death but not re-	sulting in the	underlying cause giv	∕en in Part I.	23b. Did tobacco use contribute to the cause				
					24a. Was	an autopsy ormed?	24b. Wara autopsy tindings available prior to completion of cause of death?		
					10	Yes 2 No	1 ☐ Yes 2 ☐ No		
25. Was casa rafarred to medical					ath (Check only	one)			
1 ☐ Yes 2 No	1 L Inpatiant 2		ent 3LI DOA	4   Nursing I	1.				
1 SNatural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time o Injury							
4 Homicide	28e. Place of Injury - At h building, atc. (Speci	iome, tarm, si	traet, factory, office		28t. Location City or To	Street and Numl wn, State)	per or Hura! Houte Number,		
29b. Signature and tipe of certifier	11	1					d (Month, Day, Year)		
MANTEN	MUMILLA	MU	Dan	5202	2	MAU	12, 2000 TIMORE MD 2122E . HANOUERST		
	4a Facility Name (If not institution, give still ARBOR HOSPITS)  5. Social Security Number 219 03 9298  Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arun  10e. Street and Number 682 Chestnut Sprin  11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of State (Specify) only highest grade of	4a Facility Name (If not institution, give street and number)  HARBAR HOSPITAL CAN  5. Social Security Number 219 03 9298   Sex 219 03 9298   To Age (In yrs. 219 03 9298   To Decedent   1. Decedent's Name (First, Middle, Last)  DENUER  4a Facility Name (If not institution, give street and number)  HARBIR HOSPITAL CENTER  219 03 9298  USUM 2 F 77 Yrs.  15. Social Sacurity Number  219 03 9298  USUM 2 F 77 Yrs.  10a. State 10b. County 10c. City, Town or Law 10	1. Decodent's Name (Frist, Middle, Last)  DENUER  4a Facility Name (I not institution, give street and number)  HARBOR HOSPITAL CANTER  5. Social Security Number  219 03 9298  120 M 2 F 7. Age (in yrs. last bishday)  130 M 2 F 77 yrs.  130 M 2 F 77 yrs.  140 Maryland Anne Arundel  150 Street and Number  682 Chestnut Springs Lane  150 Street and Number  682 Chestnut Springs Lane  171 Nerval Maried  172 New Armole (I not institution)  173 Was Decodent Ever in U.S.  174 New Specification  175 New Specification  175 Specification  176 Specify only highest grade completed)  177 Father's Name (First, Middle, Last)  Marshall McCabe  196 Decodent's Education  178 Institute of Call Specify  Winona McCabe Wife  208 Method of Disposition  178 Institute (I not institution)  179 Institute (I not institution)  170 Not institute (I not institution)  170 Not institute (I not institution)  Marshall McCabe  190 Not institute (I not institution)  190 Not institute (I not institution)  191 Not institute (I not institution)  192 Institute (I not institution)  192 Institute (I not institution)  193 Not institute (I not institution)  194 Not institute (I not institution)  195 Not institute (I not institution)  196 Not institute (I not institution)  197 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  198 Not institute (I not institution)  199 Not institute (I not institution)  190 Not institute (I not instition)  190 Not institute (I not insti	As Facility Name (If not institution, pive street and number)  HABBAR HOSPITAL CENTER  5. Social Security Number 219 03 9298  120 M 20 F 7. Age (Im yrs. less birtholay) 121 Hunder I year Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill Under Ill U	1. Decedent's Name (First, Modde, Last)  DENDUCABE  S. Decident's Name (First, Modde, Last)  DENDUCABE  As Facility Name (If not histlation, give street and number)  HARBY HOSPITAL CENTER  S. Social Security Number  G. Sex  219 03 928  100 215 77 yrs  Moderns  100 597  Hours  100 County  100 C	1. Decedent's Name (First, Middle, Last)   Decedent   S. R.   Middle   S. R.   Design of Death   Day   Middle   S. Social Science and number)   HARDBUR   HOSPITAL   CENTRE   ALCOHOLOGIC   Death			

Registrar

MAY 9 2000 James & MAY

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month Bervl Baldwin Neill May 11:50 AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Pickersgill, Inc. Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Dale of Birth (Month, Dey, Year) Birthplaca (State or Foraign Country) **Funeral** Deys Hours Months 1 □ M 2 X F 87 212-82-7446 Vrs Director December 16, 1912 Pennsylvania Usual Rasidence of Decedent the Maryland 10a. Slate 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov If a Medical Examiner nust be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Towson 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? death with 615 Chestnut Ave. 21204 United States Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer a Deportment of Health end Mental Hygiene. Introortant: If them 27 is merked other than "natural," or Item any injury or other traumatic event, it amounts and a 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 15. Dacedent's Education 16e. Dacedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry (Specify only highest grade completed) Elemantary/Secondary (0-12) Collaga (1-4or 5+) secretary/treasurer audio/video equip. sales 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Albert D. McClenaghan Beryl Baldwin 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Barbara Pulyer/daughter Towson, MD 601 Yarmouth Rd. 21286 20b. Place of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Crametion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Crestlawn Cemetery 5/6/00 Sykesville, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21. Signatury of Funeral Service Linguism 6500 York Rd. Baltimore, MD 21212 ent . Enler the disaese, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, hock, or heart failura. List only ona cause on aach lina. **Physician** Acute preumonia /Medical Immediate Ceuse (Finel 4 days disease or condition rasulting in death) **Examiner** Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata ceuse. Enter Underlying Cause (Diseesa or injury that initieted evants resulting in death) Lest Due to (or as a consequence of): buriel-tra Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or es e consequence of) for use Pert II. Other algnificant conditions contributing to dasth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown rementi A 99 Completed 24b. Wera autopsy findings evelleble prior to 24a. Wes en eutopsy performed? completion of ceuse of death? hes certificete 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical exeminar? Be 26. Place of Deeth (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA ၉ 1 Yes 2 No this 27. Mennar of Deeth 28c. Injury et Work? 28e. Data of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Dascribe how injury occurred : After t 1 Naturel 2 Accident 5 Pending investigation of or Attendition of the death.

I Director: At in by the fu 1 Yes 2 No 6 Could not be 3 Suiclde Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Cartifiar 12 Certifying Physician: To the bast of my knowledge, death occurred et the time, data and plece, end due to the causa(s) and manner as stetad.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and plece, end due to the causa(s) end menner stated. Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 3,2000 no 30. Name end eddress of person who complated cause of thath (Itam 23e) (Type, Print) N Charles St. Balto Md 2120x 6BMC 6 6701 1601-64 31. Data filed (Month, Day, Year) 32. Registgar's Signeture State 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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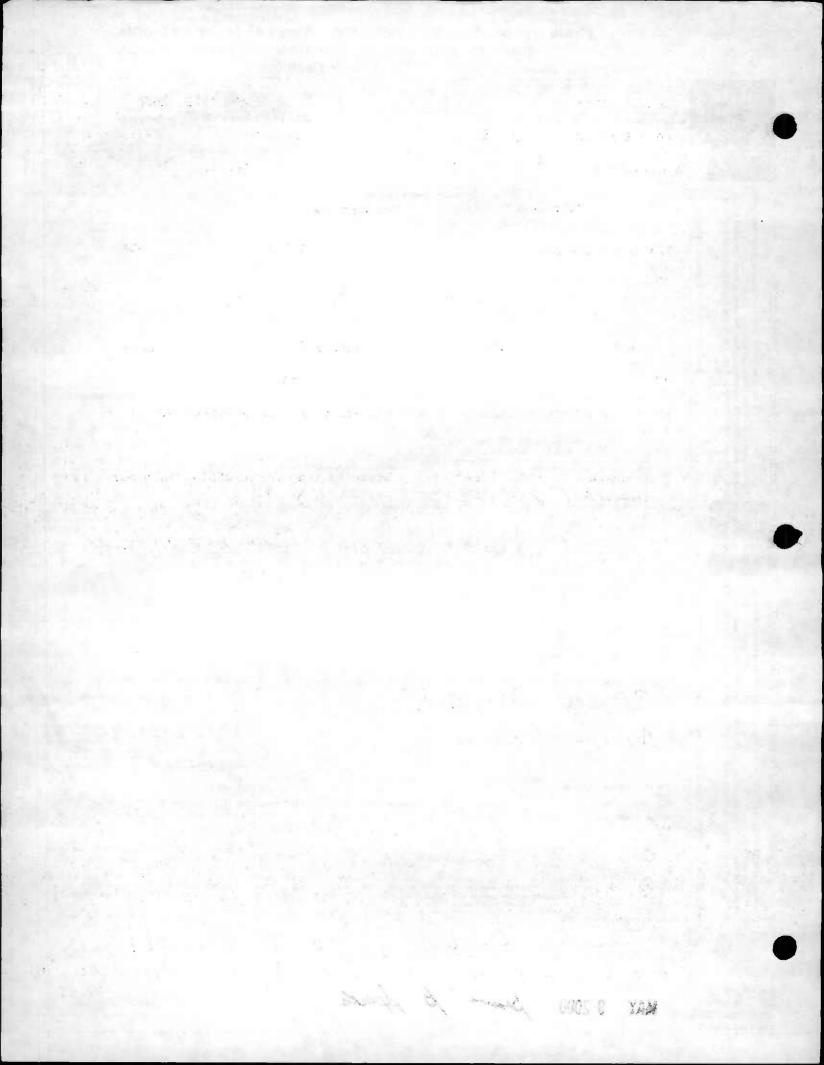
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	20b PER FH G783 5/8/			Cen	tificate (	of Death			g. No.			
sician	Decedent's Neme (First, Middle, Last)						2. Det	a of Death oth	Dey _	Yeer	3. Time of	
edical	Anna Maria Nango						Ma		7	2000	9:00	A.M
niner	4a Facility Name (If not institution						, or Location of	of Daeth	4c. County			
	Anne Arundel Medical Center					Annapo			Anne	Arun	del	
	5. Social Security Number 107–30–4971	6. Sex 1□ M 2 <b>F</b> 7.	est birthdey) Yrs.	If Under 1 Y Months Do	Yeer If Under 24 Hrs. 8. Date of Birth Deys Hours Min. (Month Day,			9. Birthplace (State or Forei Country) NY •		or Foreign		
	Usuel Residence of Decedent											
at be notified at al Director	MD. Anne	Arundel		, Town or Loc .nnapol						1	0d. fnside C	ity Limits 2 \Begin{align*} 2 \Boxed No
Director	10e. Street end Number				10f. Zip Co	de		10	g. Citizen of \	Whet Coun	ntry?	
9	1516 Lodge Pol	e Court			21	21401			USA			
Jer.	11. Meritel Stetus	12. Was Decedent Evar in U.S				? (Specify Yes or No-						
Examiner must by Funeral	1 Never Merried 2 Merrie 3 Widowed 4 Divorced	Armed Forcas? d 1 Yes 2 No If Yes, Giva Year or Detes:		If Yas, specify Cuben, Mexican  1 X Yes 2 □ No Specify:					Black, White, etc.  Specify:  White			
	15. Decedent			16a, Decede	ent's Usuel O	ccupetion		1	6b. Kind of B			
	(Specify only highes	t grede completed)		(Give k	ind of work de O NOT use re	one during most o	f working					
Completed	Elementery/Secondery (0-12)	College (1-4	or 5+)	Home	emaker				Own	Home	2	
	17. Fether's Nema (First, Middle, L	.ast)	Homemaker		18. Mother's	18. Mother's Name (First, Middle, M						
Q C	Nicasio Vernab	e				Chri	stina I	liver	a- CHRI	- CHRISTINA RODRIQUEZ		
2	19e. Informent's Neme/Reletionsh			19h. Mailing	Address /St	reet end Number						
		aughter				Pole Cou						
ł	20e. Method of Disposition		20b. Pl	aca of Dispos								
any injury or other traumatic event,	1 Buriel 2 □ Cremetion 3 □ Removel from Stete camet			dlawn	etory or other	outer pieca)			199 Location - City or Town, State Bronx, New York			
	21. Signatura of Funeral Service L  Sollet A  23a. Pert1. Enter the disease, or	Secus complications that cause	sed the deeth	St   73	erling 6 Edmo	ddress of Fecility Ashton andson Av dying, such es ca	e. Bal	timor	e, MD.		28 Approxime	te
	shock, or heert failure. List of	only one cause on eec	n iine.								Intervel Ber Onset end	Death
	Immediate Ceuse (Final disease or condition PNEU				nia					!	2 400	011
	resulting in deeth)	ase or condition e.				consequence of):				1	2000	CAG
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Examiner	Sequentially list conditions	es e consequ		600000	ricq			16		140		
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Medicai	resulting in death) Last  Due to (or es e consequence or):											
Clan	Part fl. Other significant condition	as contributing to deet	h but not rasu	Iting in the un	derlying caus	e given in Pert I	23	b. Ofd tot	acco use co	ntribute to	the cause	of death1
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ed by			24a. Was en eutopsy performed?						24b. W	ere eutopsy eileble prior	findings to	
s certificate has been signed by the attend director, page 2 should be detached for us fo Be Completed by Physician/										CO	mpletion of deeth?	ausa
								1 Ye	s 2 No	1 [	Yes 2	No
å	25. Was case referred to medical examiner?	44					f Death (Chec	k only one	)			
2	1 Yes 2 No	Hospitel.		ER/Outpatient			ing Home 5	Resider	nca 6 □Oth	er (Specif	y)	
plataly filled in by the funeral edical Certification:	27. Menner of Death  1 Naturel 5 Pending 2 Accident investig	Injury Dey Year) 28b. Time of Injury 28c. Injury et Work?  M 28c. Injury et Work?  1 ☐ Yes 2 ☐ I		Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred  No							
200	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, off building, etc. (Specify)				ffice 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)							
dical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Phyeician: To the be examiner: On the basis end manner	s of exeminati	vledge, deeth ion end/or inve	occurred et the estigation, in a	ne time, date end ; my opinion, deeth	place, end due occurred et th	to the ce e time, da	use(s) end m te end place,	enner es s end due to	teted. the ceuse(	s)
Me	00. 1							d (Month,	Dey, Year)			
	> Ltuart	E. Selvicilis U.D. D19838 5171 the completed causa of death (Item 23e) (Type, Print) elouich, U.D. 900 Bestgail Rd. Annapolis, M						1200	00			

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once.  To Be Completed by Funeral Director	48			rsing Home			Baltin			timo	re
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by Funeral Director	11.	Marital Status  1 🖾 Navar Mari  3 🗆 Widowed	rried 2 Married	12. Was Dacedant E Armed Forces? 1 ☐ Yas 2 ☐ N If Yes, Giva Yaer or Datas:	lo	13. Was Decedant If Yas, specify (		n? (Spacify Yas or N Puerto Rican, atc.)	o- 14. Rac Blac Specify	ck, Whita,	cen Indian, atc. white
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00-2452-510 Gerald Owens

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State of Maryland / Department of Health and Mental Hygiene 4880 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death May 02, 2000 **Physician** 6:00P.M. GERALD LAMONT OWENS /Medical 4a Facility Name (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore John s Hopkins Hospital if Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 215-88-1500 Usuel Residence of Decedent 1 M 2□ F APRIL 05, 1976 MAR Yrs. Director with the Maryland 10a. Stata 10c. City, Town or Location I ehow 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 shown all higher or other traumatic event, the Medical Examiner must be notified at page. 1 Yes 2 No Directo ALTIMORE MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code AVENUE Funeral E 14. Race - American Indian, 12. Was Decadent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marifal Slelus Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced BLACK Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 9+HGRADE College (1-4or 5+) UNEMPLOVED 17. Fethar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JERALD SR. 20 DARLENE JAMES 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 329 MARTINGATE AVE, BALTO, MD. 21229 GERALD L. OWENS SR. (FATHER) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date / 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete ARBUTUS CEMETERY US-09-00 ARBUTUS, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) Rant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory effect,

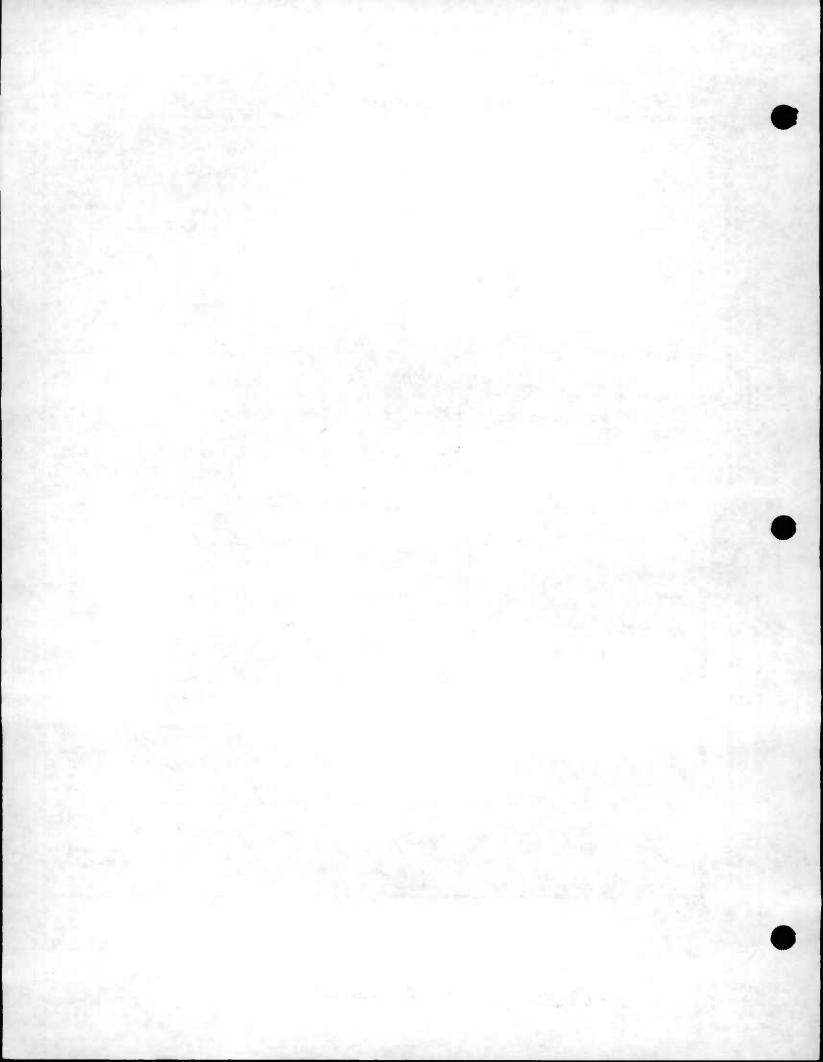
Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory effect,

Approximate 21. Signature of Funeral Service License BROWN JR. FUNERAL HOME Approximete Interval Between Onset end Death **Physician** Wound of Head /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physician/Medical Examiner ician and burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Diseese or injury that initiated avants resulting in deeth) Lest Due to (or as a consequence of): Box 68760. Due to (or es a consequance of) usa P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? Aftar this cartificata has paga 2□ No 1 Yes 2 No Division of Vital or Attending Physicien: funaral director. Be 25. Wes cese referred to medicei 26. Piece of Death (Check only one) Hospitel: 1 → Ampatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Spacify) Certification: To XX Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred subject shot 5 Pending investigation 1 Naturel Injury after death.

Director: After the director of the director of the fundamental of the fund 1 | Yes 2 | € No 2 Accident 5-1-00 2033p 3 Suicide 6 Could not be determined 281. Location (Street and Number or Aural Route Number, City or Town, Stete) 824 Argenne Drive Baltimore, Mil 28e. Piece of injury - Al home, farm streef, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di complataly filled in sidewalk 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the ceuse(s) end menner es steted.

\*\*\*Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner steted. Medical 29a, Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) O.C.M.E. May 03,2000 luter m and cause of deeth (Item 23a) (Type, Print) 5 hute 111 Penn Street, Baltimore, Maryland 21201 09.2000 31. Dete filed (Month

Registrar DHMH 16 Rev 6/95

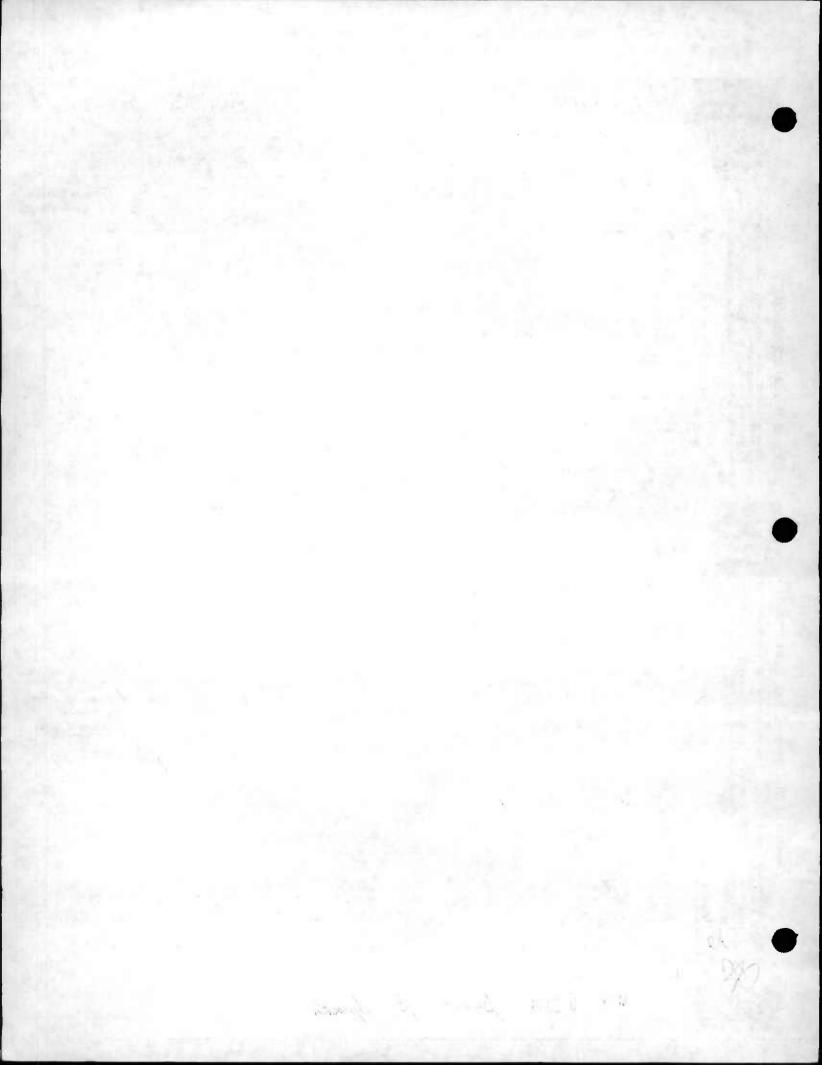


State of Maryland / Department of Health and Mental Hygiene 488 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev Month Year **Physician** 3:15 p.m MARY C. OTTERBEIN 2000 101 2 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner UNION MEMORIAL HOSPITAL BALTIMORE BALTOMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1□M 2 1 F MARYLAND 84 Yrs. 215-09-2859 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MARYLAND BALTIMORE CITY Director BALTIMORE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number permit. Peges 1 and 2 should be filed within 72 hours efter death v. Department of Heath and Mentel Hygiene. Important: If fem 27 is merked other than "natural", or items 23s any injury or other traumatic event 2707 RITTENHOUSE AVENUE UNITED STATES 21230 Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN McALEER CLARA SHELTON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 8277 19a. Informant's Name/Relationship (Type, Print) 1096 WEST VIEW RIDGE DRIVE, OAK HARBOR, WASHINGTON MARY E. MELTON-DAUGHTER 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from Stete LOUDON PARK CEMETERY 5-6-00 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Euneral Service Licens 22. Name and Address of Fecility OUDON PARK FUNERAL HOME LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical 30 minutes cardio pulmonary Examiner Due to (or es a consequence of) Physician/Medical Examiner Affer this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Oue to (or es e consequence of): Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? Be Completed 200 No 1 🗆 Yes 200 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Medical Certification: To 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dele end placa, end due to the ceuse(s) end menner steted. 29a. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of cartifier 10 191965 MO 30. Neme endleddress of person who completed cause of death (Item 23a) (Type, Print) Parkway Baltimore, MO 21218 Jarrott Moore 201 East MO 31. Dete filed (Month, De 32. Registrer's Signature

Registrar

2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** 6, 2000 Anna Dorothea Perry 12:30PM Mav /Medical 4e Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3004 N. Ridge Road, Ellicott City Apt. 413 Howard | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day), Year | DEC 20, 1916 9. Birthplaca (State or Foreign Country). New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M X F Yrs 83 001-14-8665 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f ahow items 23a or 28a-f ahov ner must be notified at 1 ☐ Yes X ☐ No Director Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Ridge Rd., Apt. 413 3004 N. 21043 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Heelth end Mentel thyglene. Important: If Item 27 Ia marked other than "natural", or iter any Injury or other traumatic event, the Medical Examinat 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 21215-0020 Specify: White 1 Yes 2 N No Specify: þ 3 Widowed 4 Divorced of the matural of other than "natural event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Romolo Cattabriga Teresa Ginocchio 19a. fnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Teresa P. Moller/Daughter 9857 Diversified Ln., Ellicott City, MD 21042 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ★ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 5/8/00 Baltimore, MD 21. Signeture of Funeral Service Licanses Chil <sup>22</sup>Cremation Society of Maryland, Inc. Edward A. Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervaf Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) -ere prova Scular **Examiner** Due to (or es e consequence of): Examiner 14 per Tensian physicien end s the burial-trensit The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): 23b. Dfd tobacco use contribute to the cause of death? Pert ff. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Part f. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation e Hospital or Attending n 24 hours after death. e Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. Medical 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end pleca, and due to the cause(s) end menner steted. (Check only one) 29b. Signatura and titla of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 0000 mo 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 958 21042 pld my Ellicott beller Steven

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Dey, Year)

ORIGINAL

32. Registrer's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Yeer Physician MAY OBERT 2000 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner CENTER DNG MORE If Under 1 Year 8. Dete of Birth (Month, Dey, Year) AUG - 20/9/5 5. Social Security Number Birthplace (State or Foreign County) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 2/2-09-440) Usuel Residence of Decedent Yrs. Director 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow if Health and Mantal Hygiana. Ham 27 Is marked other than "natural", or hams 23s or 28s-f show other traumstic event, the Medical Examinar must be notified as 1 Yes 2 □ No Director BAUTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 40 WOOD Funeral 12. Was Decedent Ever in U,S. Armed Forces?

12. Yes 2 □ No
41 tes, Give
Yeer or Dates: WWT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) ANTENCE pemit. Pages 1 and 2 should be file Department of Health end Mentel Hy Important: If Item 27 Is marked oth any Injury or other traumatic avant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code) 2/093 19a. Informent's Neme/Reletionship (Type, Print) -# OBERT H. 203 / IMONIUM HD 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 Cremetion 3 Removel from State Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility HUDSON ST DATIMORE Approximete Interval Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory errest, Physician tmmediate Cause (Finel disease or condition resulting in death) /Medical · CARDIO PULMONANY MIG GOLLETE Examiner Due to (or as a consequence of): NEU MONII Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. ERENAL VASCULAR /CCIDEN Physician/Medical Due to (or as a consequence of): HRTENIOSCLERUTIC Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown s been signed is should be det Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 2 JNo 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director; After this certifica completaly filled in by the funeral director, 25. Wes case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 PNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 CHatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted. (Check only one) 29b. Signature end title of certifier 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1016 M.D n

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month Day, Year)

32. Registrar's Signature

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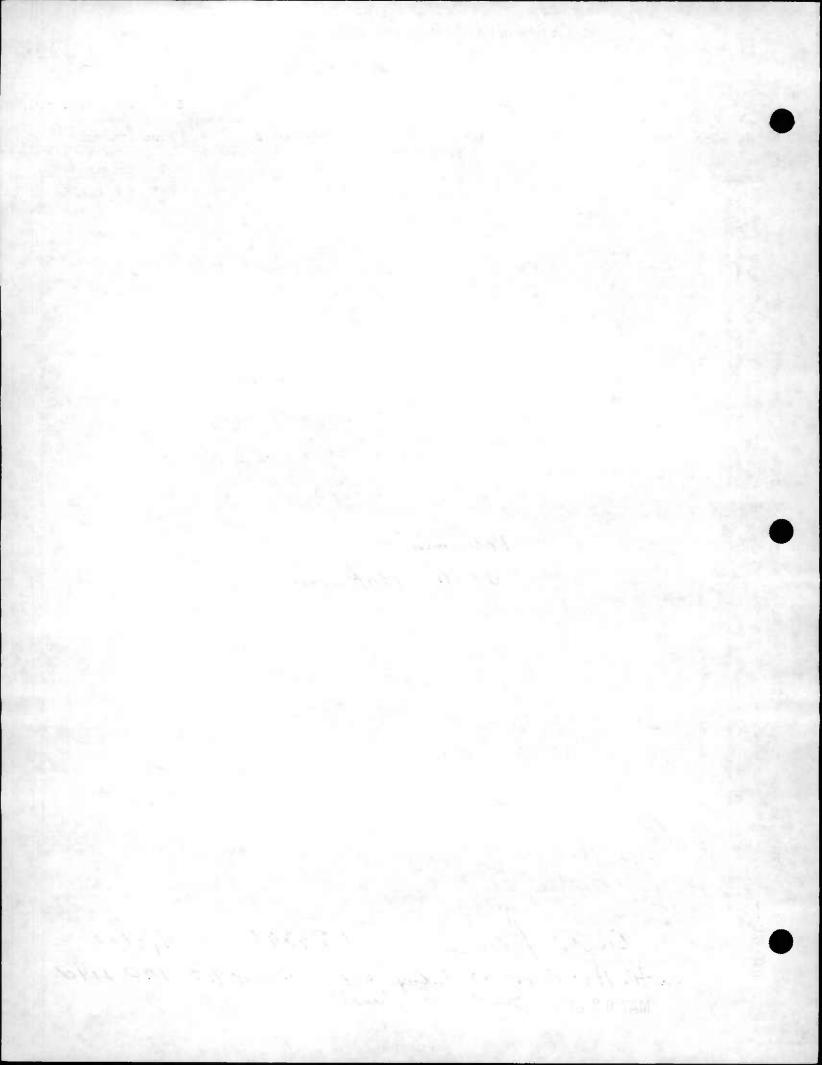
State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Name (	(If not institution,	giva street ar	nd number)					4b. City, Tov	wn, or Lo	cation of Deat	4c. Coun	ty of Death		
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uneral irector	5. Social Security P 216-36-		6. Sax 1XXM 2□	7.6	(In yrs. last	t birthday) Yrs.	If Unda Months	r 1 Yaar Days	If Undar : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 26	th ly, Year) ,1917		place (State htry) land	or Forei
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e man	19a, Informant's N	ame/Relationshi	ip (Type, Prin	t)		19b. Mailir	ng Addras	s (Street	and Numbe	r or Rur	al Routa Numb	er, City or Tow	n, Stata, Zip	Code)	
other tr	Anna L.	Prout (	Wife)							, Lo	othian,	MD 207			
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Ĕ	Peges nent of I mt: If ite		1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Ramoval from Stat cify)	a Holl			etery.	11 2000	MIDDLE	- Qive	er MD.		
alti	permit. Peges Depertment of Important: If It any Injury or c		21. Signature of Funeral Service Li	**	T TOLK									
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			23e. Part1. Enter the disease, or o	mplications that cause	ed the death. I	Do not enter the		ARFORD RE			11934	Approximete		
90			shock, or heart feilura. List or	iy one ceuse on each	tine.	SO NOT OTHER THE	nodo or dy	ng, saari aa saratas t	or recognition y a	11001,		Intarval Batween Onset and Daath		
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ă	d in D	en	4  Homicida	building,	etc. (Specify)				City or To	wn, Stata)				
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	()		30. Neme and address of person w	no completed cause of	deeth (Item 23	Ba) (Type, Print)	11	inemail II	look in	relian (	13	Stimore, MD		
			7. Mattingly, M	1) 22 S	outh Gri	eene ST	, Uni	VE13/18 01 /	wy and I'v	conces Joseph	m, ra	John Grey 1		
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DHMH 16 Rsv 6/95

MAY BIDDE VAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14886 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Daeth PORTERA **Physician** 1:18 A.M. J. ,2000 CARMEN MAY 5 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner STELLA MARIS HOSPICE of MERCY HOSPITAL BALTO N/A If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) f Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1**2** M 2□ F 217-09-2515 Yrs. Director Dec, 31,08 Miss. Usuel Residence of Decedant r 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1₽Yas 2□No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? r than "naturel", or items 23s or the Medical Examiner result be n 21201 15 CHARLES PLAZA USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bleck, Whita, atc. 1 Yas 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pemit. Peges 1 and 2 should be filed within 72 Department of Heilth end Mentei Hygiene. Important: If Item 27 le merked other than "natheny injury or other treumatic avent, the Medica 2006. RELIGIOS ORCANIZATION College (1-4or 5+) Elementery/Secondary (0-12) SEXTON 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) B FRANCIS TESTA SALVATORE PORTERA 2 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) 15 CHARLES PLAZA BOLTO, MA-21201 (wife) MARY PORTERA 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete P⊠ Burial 2 ☐ Cremetion 3 ☐ Removal from State MAYS OLY REDGEMER BACTO Md. 4 ☐ Donation 5 ☐ Other (Specify) 2000 22 Name and Addrass of Fecility DELLA NOCE & SONS FUNERAL HOME 21. Signature of Funeral S. HIGH ST. BALTO. Md 21202 C.K 322 sa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory errast, List only one cause on each line. Approximeta Intervel Batween Onset end Death **Physician** /Medical Immediata Causa (Final 2 WEEKS SEVENE WASTING AKD DEBILITA TION disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner DIFFUSE BONE AND PULMONANY METASTASES ZMONTHS physician and s the burial-trensit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last LUNG SQUAMOUS CELL CARCINOMA Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown DEHYDRATION Records, à CHRONIC OBSTAUCTIVE PULMONARY DISEASE 24a. Was an europsy 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? Completed 1 ☐ Yes 2 No 1 Tyes 2 No of Vitai 8 25. Was case referred to medical 26. Place of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) HOSDIC & 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred i or Attending F Division 5 Pending investigation 1 Maturel 1 Yes 2 No To the Hospital or Attenditional within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar **DHMH 16 Rev 6/95** 

State

29th Figneture and title of certifier

31. Dete filed (Month, Day, Year)

MAY

oreph D.

ima and address of person who completed cause of death (Item 23a) (Type, Print)

9 2000

32. Registrer's Signature

M.D

29c. License number

OSEPH D. NO TARANGELO M.D. 301 ST. PAUL PLACE - BALTIMONEMO 21202

DO 7316

29d. Date signed (Month, Dey, Year)

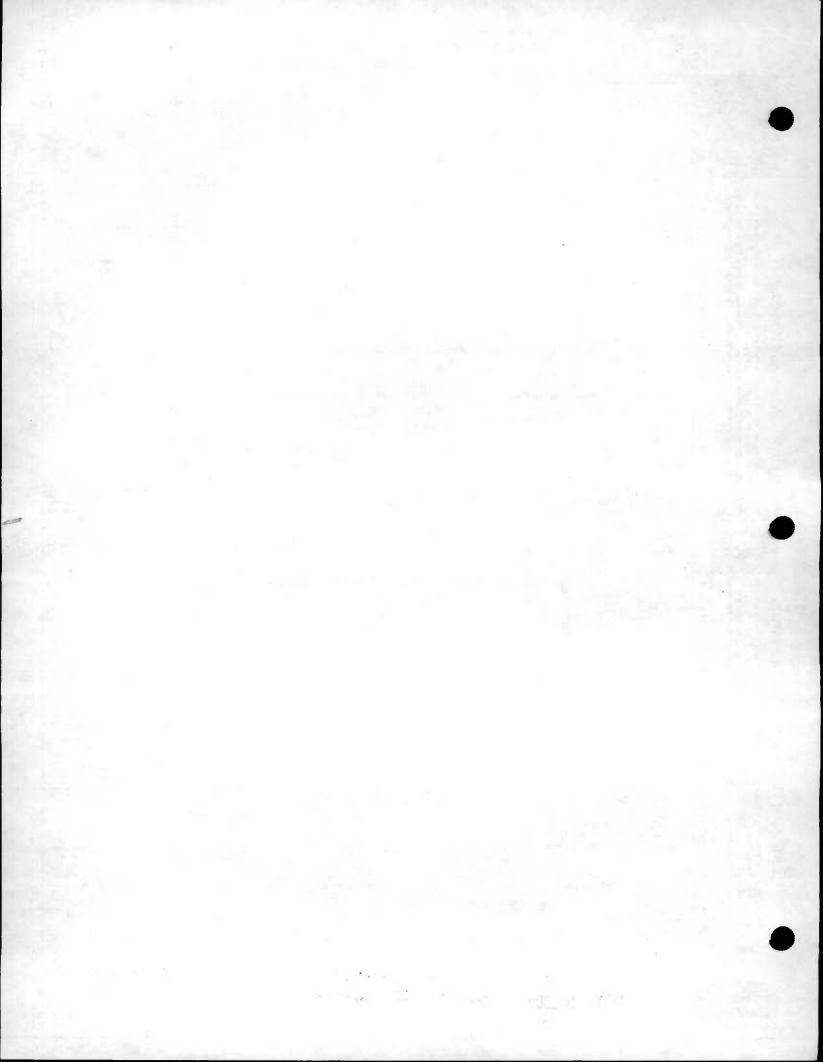
MAY-5-2000

AND THE STATE OF THE PARTY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Lidgway Kegina 6:55 AM May 4 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Nema (If not institution, give street and number, 4c. County of Death Examiner Baltimore Sinai Hospita If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 59 Yrs. If Under 1 Year 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) **Funeral** Days 1□M 2☑F 217-38-6067 Director March 31, 1941 MD Usual Rasidence of Decedant the Meryland permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Merylan Department of Health end Mentel Hygiene.
Important: if item 27 le marked other than "naturel", or itema 23a or 28a-f show any highry or other treumatic event, the Medical Examiner must be notified at once. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Lansdowne 1 ☐ Yas 2 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Third Ave. 21227 U.S.A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yes 2 ☒ No If Yas, Giva Yaar or Datas: 1 Navar Married 200 Married White 21215-0020 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) St. Clements Church 10 Secretary Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Rita E. Callan Robert A. Stevens Lo 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 121 Third Ave. Lansdowne, MD. 21227 Charles A. Ridgway, husband 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata to Burial 2 ☐ Cramation 3 ☐ Ramoval from State Meadowridge Memorial Park5-8-00 4 ☐ Donation 5 ☐ Othar (Specify) Dorsey 21 Signatura of Funaral Sarvice Licans 22. Nama and Addrass of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a Part 1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final 10 minutes diseasa or condition rasulting in death) 40Cardia Examiner Examiner mary years Arterosclerotic physicien end s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): 98 USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 JUnknown Records, ٥ 24b. Ware autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy pege 2 s hes 1 Yas 2 WNo 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No edicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not ba 3 Suiclda 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifiar end mannar steted. 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) D4376 6,2000 Molench MO Trankley 30. Nama and addrass of person who complated causa of daeth (Itam 23a) (Type, Print) Belvedere Ave, Balto, MO 21215 Broderick J Franklin Sinai Hospital 2401 MO 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Ouks 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #20c PER FH G783 5/9/2000 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth MARY ROBINSON **Physician** 2. Dan 2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MACHINA BACTIMURE

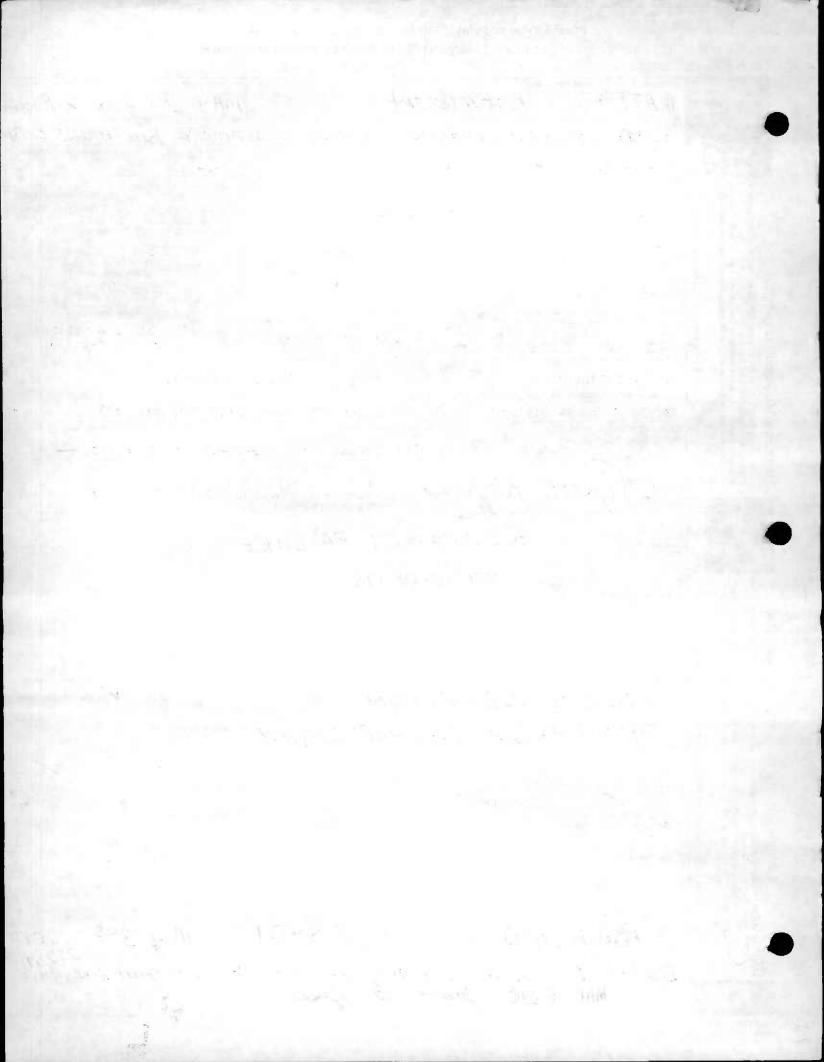
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Deys | Hours | Min. | Month, Dey, Yeer,

7-8-1939 RAJIMORE CIT SAMARITAN HOSPITAL 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 100 M 2□ F Yrs 219-26-4933 Md **Director** Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Depertment of Health and Mental Hygiane.
Important: If teem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other treumatic event, its Medical Exprise. This I has not injury or other treumatic event, its Medical Exprise. 1 XYes 2 No Director Md N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 3737 Clarks Lane Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 Black 1 ☐ Yes 2 ☐ No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuef Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State Division Elementary/Secondery (0-12) College (1-4or 5+) Manager Pre Release of Corrections Master s Degree 12th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Theresa Washington Marion Robinson 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Baltimore, Md 21229 Theresa Rodgers- Sister 4605 Coleherne Road 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Garrison Forest Veteran 5-10-00 Owings Mills, Ms 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 res 23a. Fart1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** FAILURE /Medical Immediete Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) attending p n signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No P 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed AND HYPOTEMSIUM 24a. Wes en eutopsy peen is certificate has b 2 INO 1 □ Yes 1 ☐ Yes 2 LING al or Attending Physician: T s effer death. I Director: After this certificat ed in by the funerel director, pa Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Depatient 2 ER/Outpetient 3 DOA Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Manger of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours eff To the Funeral Di 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. edicai 29a. Certifier 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29b. Signature and ettle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address operson who completed ceuse of deeth (Item 23e) (Type, Print) HOSP, OF MD, SLOT LOCH RAVIEY SAMARITAN DOD

2000 32. Registrar's Signeture

State Registrar 31. Date filed (Month

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0 14889

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4890 Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Day **Physician** Month MARGARET ROCHOWIAK 2000 9:40 P.M. MAY /Medical 4e Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE 3806 ELMLEY AVENUE If Under 1 Yeer If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)
MAY 14, 19 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (Stete or Foreign **Funeral** 1 M 2 F MARY LAND Yrs. 74 Director 219-16-9718 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director MARYLAND BALTIMORE 10a. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? ð 238 3806 ELMLEY AVENUE U. S. A. 21213 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Stetus filed within 72 hours after 1 ☐ Yas 2 No If Yas, Giva Yeer or Detes: 1 ☐ Never Merried 2 X Married "natural", or I adical Examin Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) HOMEMAKER 11TH GRADE OWN HOME permit. Pages 1 and 2 should be tite Cepariment of Health and Mental Hy Important: if them 27 is marked offor any Injury or other traumatic event BODS. 17. Fether's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be STEFAN SURMASZEWICZ HELEN JASKULSA 19a. tnformant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MR. DANIEL ROCHOWIAK (HUSBAND) 3806 ELMLEY AVENUE, BALTIMORE, MARYLAND 21213 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS 5/9/00 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee SCHIMUNER FUNERAL HOME INC. Make 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 ations that caused tha death. Do not entar the mode of dying, such as cardiac or respiretory errest, 23a. Pert1. Entar tha diseal shock, or haart faitura. **Physician** not à Liver kung Mets Immediete Causa (Finat disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, teeding to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last Dua to (or es e consequence of) Due to (or as a consequence of): Box P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should be 24a. Wes an autopsy performed? 24b. Were autopsy findings eveilable prior to Completed completion of cause of daeth? 1□ Yes 2 No certificata 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 26d. Describe how injury occurred 28c. Injury at Work? 1 Divaturel 5 Pending 24 hours after death.

Funeral Diractor: A 1 TYes 2 TNo investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 Suicide filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Cartifier completely (Check only one) To the To the To the F 29b. Signetura end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) anti a Surgene Dluces 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arthur Ser eice 760 ( 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2000 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death Month **Physician** KAKE tildegard 00 /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Health of 9km Burnie Home Arundel If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 212-36-385 Deys 1□M 2XF Yrs. Director 10 Germany Usuel Residence of Decedent death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1 Yes 2 No Funeral Director Anne Arundel Glen Burnie 10a. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7924 Allard Court #102 21061 U.S.A. permit. Peges 1 end 2 should be filled within 72 hours after deat Department of Health end Mental hygiene. Important: If fier 27 is marked other than any injury or other trainer. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Giva Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Be Completed by Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7th Homemaker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Paul Max Niedergesass Martha Emma Scholz 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lawrence Rake ( Husband ) 7924 Allard Court #102 Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 5/8/00 Glen Burnie, Maryland 21. Signature of Furieral Secrice Licensee Kevin E. Ecker 22. Name end Address of Fecility
McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical EMBOLIC OVA Examiner Due to (or es e consequence of): CHRONIL NON VALVULAR The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or injury that initiated events rasulting in deeth) Lest Due to (or es e consequence of): CORONARY Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown C.O.P.D Completed by GANGRENE RIGHT L.E. 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? MELLITUS - 2 DIAGETES 1 Yes 2 No 1 Yes 20 No Division of Vital or Attending Physician: 25. Was cose referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28e. Deta of Injury (Month, Day Year) 27. Mennar of Deeth 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Neturel s after des. al Director: After 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steled. 29e. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetura and title of certifier emaying MO.

**DHMH 16 Rev 6/95** 

State

Registrar

30. Name end eddress of person who complated ceuse of death (Item 23a) (Type, Print) 32. Resistrer's Signature

2000

710 CHURCH ST- BALTIMORE, MD 21225

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MAY 4, 2000 **Physician ALEKSANDR** RAYKIN 4:28 PM /Medical 4c. County of Death 4a Facility Nama (ff not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14 RICHMAR ROAD #I OWINGS MILLS BALTIMORE If Undar 1 Year | If Undar 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Months 1⊠M 2□ F 214-49-7623 **Director** 58 JULY 3, 1941 **BELARUS** Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits show 1 ☐ Yas 2 No BALTIMORE Director OWINGS MILLS "natural", or flarms 23a or 28a-f 10e Street and Number 10f Zin Code 10g. Citizan of What Country? 14 RICHMAR ROAD #I 21117 **BELARUS** Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hyglene. 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 📉 No If Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) DISHWASHER RESTAURANT 17. Fathar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be is marked MICHAEL RAYKIN FRUMA 2 WOLFSON 19a. fnformant's Name/Retationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any Injury or other tran BELLA RAYKIN / WIFE 14 RICHMAR ROAD #I - OWINGS MILLS, MD 21117 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from Stata BALTIMORE HEBREW CEMETERY 5/7/00 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, use on each line. Approximata tntarval Batween Onsat and Daath **Physician** Mousive metastatre plesval effesting to Nexportation failure, lung metastases. /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificate be executed attending physician and for use es the bunal-tran Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Box 68760, P.0. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, ģ 24b. Wera eutopsy findings evailable prior to complation of causa of daath? 24a. Wes an autopsy performed? Completed peen certificate has page 1 Yas 20 No 1 Yas 2 No or Attending Physician: after death. Be 25. Was casa rafarred to medical 26. Plece of Deeth (Check only one) axaminar? Hospitel: 1 | Inpatiant Other: 4☐ Nursing Homa 5 Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No edical Certification: To 2 ER/Outpatient 3 DOA this 27. Mannar of De 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the causa(s) and mannar stated. 29a. Cartifier 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and titta of certifier Venu w 30. Nama and address of person who completed ceusa of daath (Itam 23a) (Type, Print) DAVID JOHN PENN 3635 OLD COURT ROAD BALTIMORE,

**DHMH 16 Rev 6/95** 

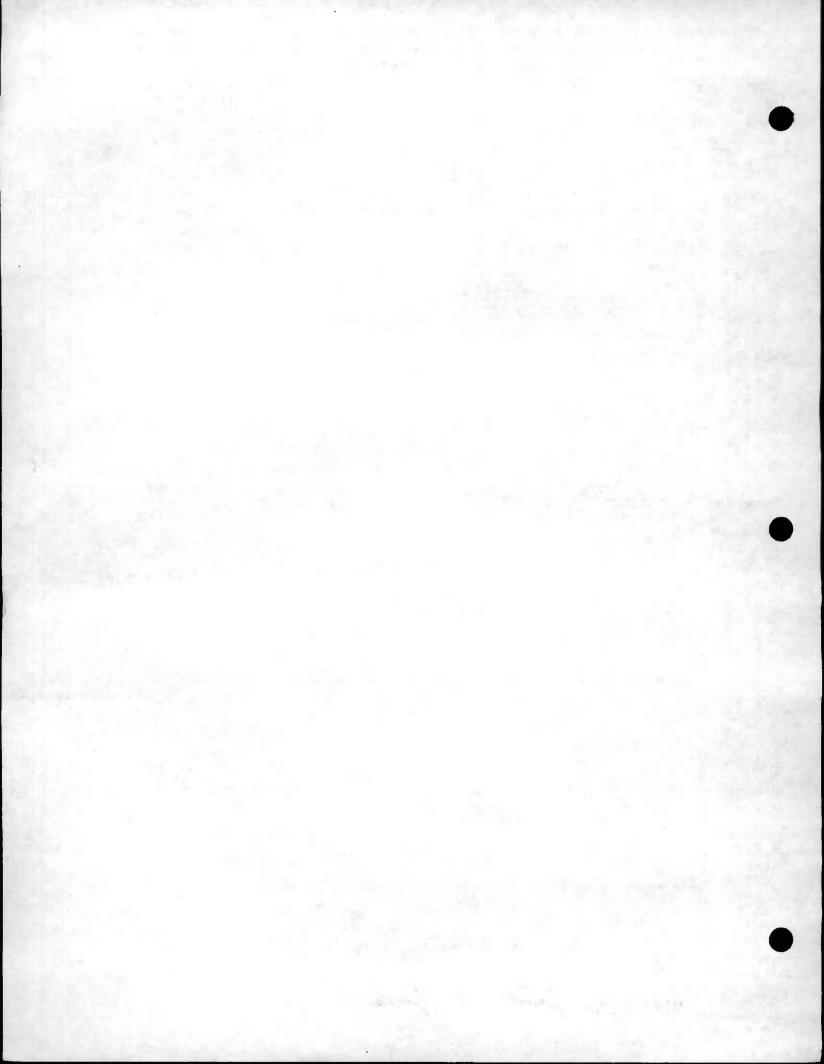
Registrar

31. Data filed (Month, Day, Year)

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32 Registrary Signature

MD. 21286



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4893 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month Yaar 8:45 AM Mau **ROZMAN** SHLEMA 2000 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and nymber) 4c. County of Death 8 pita +I MOVE N/A 0 timore H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) MAY 26, 1918 If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Months Days 1 M 2□ F UKRATNE 213-37-8460 81 Usual Residence of Decedent 10a. Stala 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 □ No N/A BALTIMORE 10e. Street and Number, 10f. Zip Coda 10g. Citizen of What Country? 21215 5900 PARK HEIGHTS AVENUE #207 U.S.A. 12. Was Decedant Evar in U,S Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 X Married WHITE 1 Yas 2 X No Specify: '3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ DENTAL. DENTIST 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) GITA-LEE FELDBLUM ELE ROZMAN 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) YELIZAVETA MALINSKAYA / WIFE 5900 PARK HEIGHTS AVE., #207 - BALTIMORE, MD 21215 20b. Placa of Disposition (Nama of cametary, crematory or other placa) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data Buriel 2 Crametion 3 Ramoval from State BALTIMORE HEBREW CEMETERY 5/8/00 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 tion—hal caused the death. Do not enter the moda of dying, such as cardiac or raspiretory errest, Approximata Intervel Between Onset and Death Immedieta Cause (Final diseasa or condition rasulting in daath) Due to (or es e consequence of) Sequentially list conditions, if any, laading to immediata cause. Entar Undarfying Cause (Diseese or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

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**Funeral** 

Director

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Maryland 21215-0020

Baltimore,

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Examiner attending physician for use as the buria Physician/Medical þ Completed certificate Be P funeral Certification: or Attending P after death.

Director: Aft
d in by the fur

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

Physician:

24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performad?

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25. Was case referred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death
Natural
2 Accidant 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding Investigation 1 Yas 2 No 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 3 Suicide 6 Could not be determined 4 Homicide

Certifying Physician: To the best of my knowledga, death occurred at the time, date end plece, and due to tha causa(s) and manner es steted.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, end dua to the causa(s) end menner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and titla of cartifiar 29c. License number

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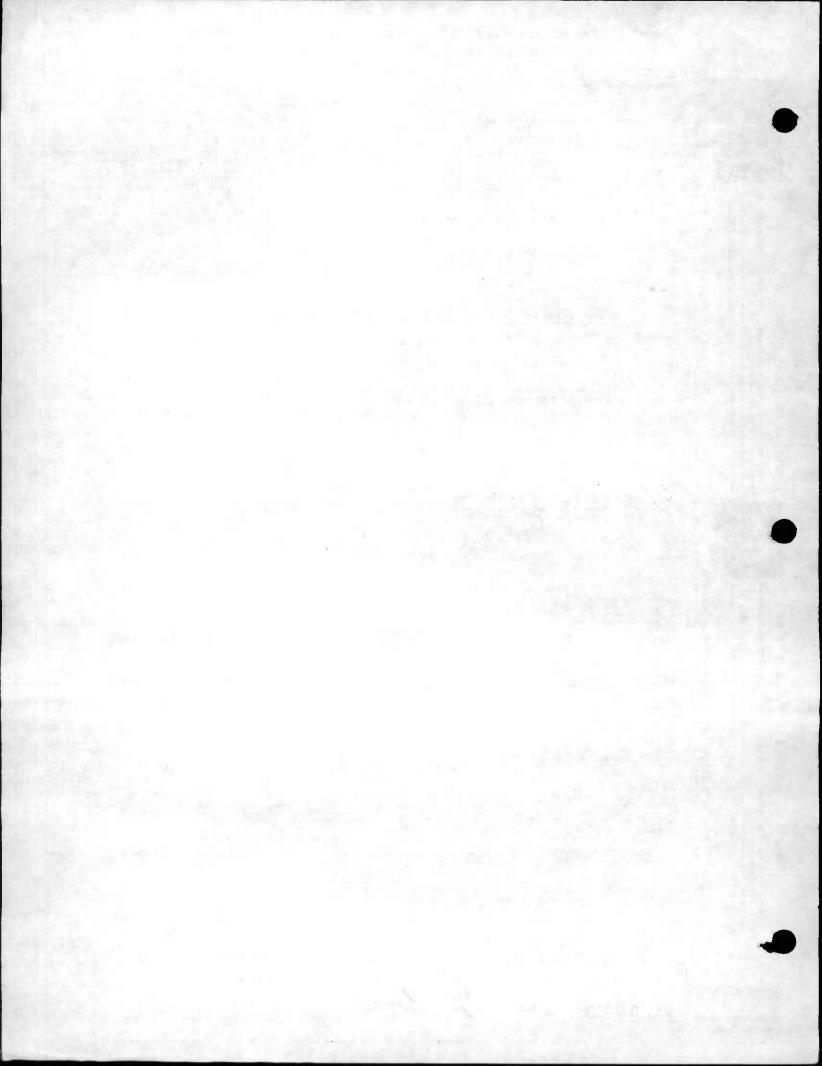
Nama and addrass of person who comp d causa of death (Item 23a) (Type, Print) Ha

Belvedera Baltimore uona 32. Registrer's Signature 31. Data filed (Month, Day, Year) MAY 0 9 2000

Registrar

within 24 hours aft To the Funeral Di completely filled in the Hospital

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** ALAYNA KOELECKE MONROE 10 11:40 PM 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL

5. Social Security Number | 6. Sex N/A PALTIMORE If Under 24 Hrs. 8 Hours Min. ITY ENTER If Under 1 Year 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 20 F Yrs. Director 01 2000 MARYLAND NFANT Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits nd 2 should be filed within 72 hours efter death with the Marylan thit end Mental Hygiene. 71 is marked other than "natural", or liems 23a or 28a-f ahow traumatic event, me Medical Examine must be notified as 1 Nes 2 No Director BALTIMORE ANNE ARUNdel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4. Race - Americen Indian, Black, White, etc. MATTHEWS AVENUE 21225 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA NFANT permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important if Item 27 is market hy, injury and i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Be FRANKLIN OC OTT LYNN SMITH 2 MAN DY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore, Maryland 21225 Barbara Smith / Grandmother 823 Matthews Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Glen Haven Memorial Park 5/8/00 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility Gonce Funeral Home, P.A. 21. Signa of Funeral Service Licensea 4001 Ritchie Highway Baltimore, Maryland 21225 romerou cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner bunisl-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last and physician Box 68760 Physician/Medical the Due to (or as a consequence of) 98 attending nse signed by the atte 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 21 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No or Attendiation after death the 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Cretifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated. edicai 29a. Cartifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year)

N.R. Agwuna M.D. 31. Date filed (Month Pay Year)

32. Registrat's Signature

100 May 2nd 00

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Gwyna

3001 South Hanover Street

D44795

Baltimore, Maryland 21225

State Registrar

VAN

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Day (C) 7 **Physician** 2000 MAY 5:30 AM Charles Milton Schneider /Medical 4c. County of Death Baltimore 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson | If Under 1 Yaar | If Undar 24 Hrs. | Months | Deys | Hours | Min. | Min. | Dec. 27 1912 5. Social Security Number 6. Sex 7. Age (in vrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 F Months Yrs Maryland 215-10-5008 Director Usual Residence of Decedent death with the Maryland 10e. Stete 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Cockeysville 1 ☐ Yas 2X No **Funeral Director Baltimore** MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21030 or items 23a 10314 Malcolm Circle, Apt. D 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Dacedent Evar in U.S. Armed Forces? 14. Race - Amarlcan Indian. 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 XNo Specify: Specify: Be Completed by 3 Widowed 4 Divorced Yaar or Dates: natural". 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondery (0-12) College (1-4or 5+) MD Cup Corp. Asst. Traffic Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be fit Department of Heath and Mental I Important: If frem 27 is mericed of any liqury or other traumatic even pass. Mary Chaney Andrew Schneider 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10314 Malcolm Circle, Apt. D, Cockeysville, MD 21030 Evelyn S. Schneider/wife 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 5/9/00 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium. MD 21 Signature of Funerel Sarvice Licens 22. Name and Address of Fecility Lemmon Funeral Home Dulan Bryan W. 10 W. Padonia Rd., Timonium, MD 21093 Clary 23a. Pert1 Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** ACUTE MYOCARDIAL INFARCTION Immediate Sausa (Final disease or condition resulting in death) /Medical **Examiner** Due to (or as a consequence of): Physician/Medical Examiner CARDIOMYOPATHY The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequenca of): use es the bunai-trar P.O. Box 68760, Dua to (or es e consequence of). Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sete hes been signed by the page 2 should be detech 1 | Yee 2 No 3 ☐ Probably 4 ☐ Unknown RENAL FAILURE Division of Vital Records, 2 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy parformed' certificete 1 ☐ Yes 2 No Attending Physician: funeral director, 25. Wes case referred to medical 26. Plece of Death (Check only one) examiner? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Netural 2 Accident 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steled. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and menner steled. Medical

State Registrar 29b. Signeture and titla of certifier

ONINO

JOGINDER P.

**DHMH 16 Rev 6/95** 

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M. D. . 32. Registrer's Signetura

30. Name and edgress of person who completed cause of deeth (Item 23e) (Typa, Print)

2000

MEHTA,

29c. License number

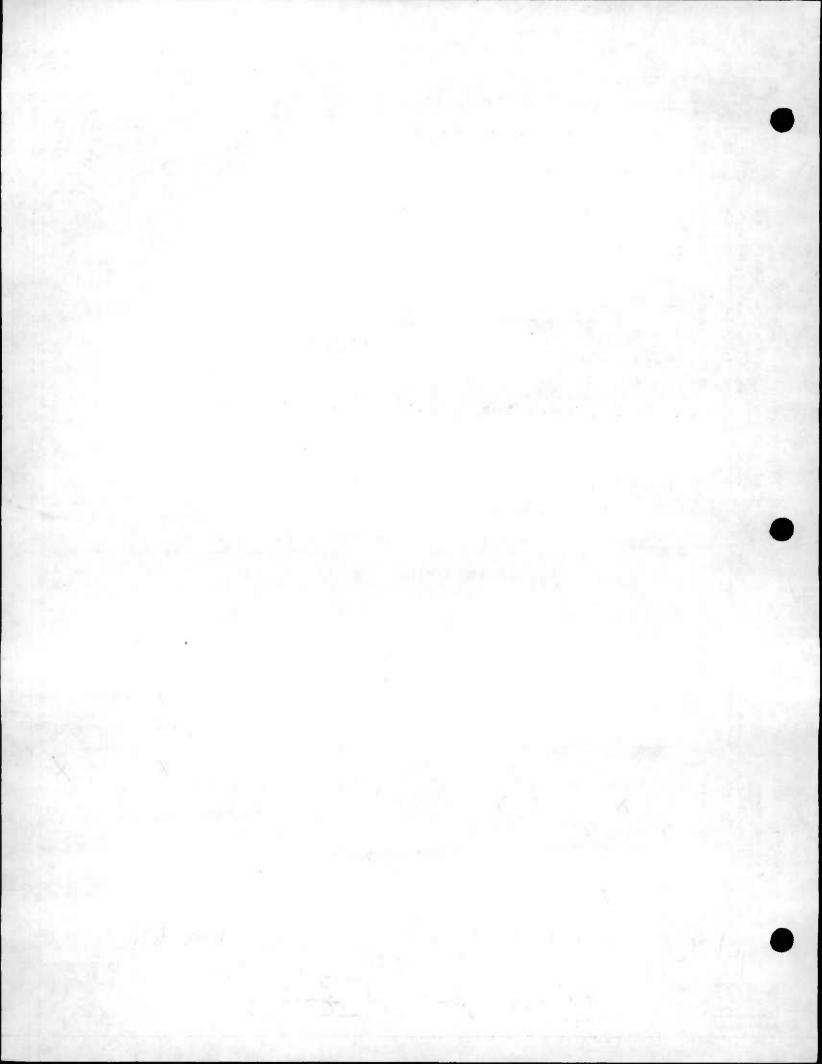
D 41410

7601 OSLER DRIVE,

29d. Date signed (Month, Dey, Year)

TOWSON, MARYLAND 21204

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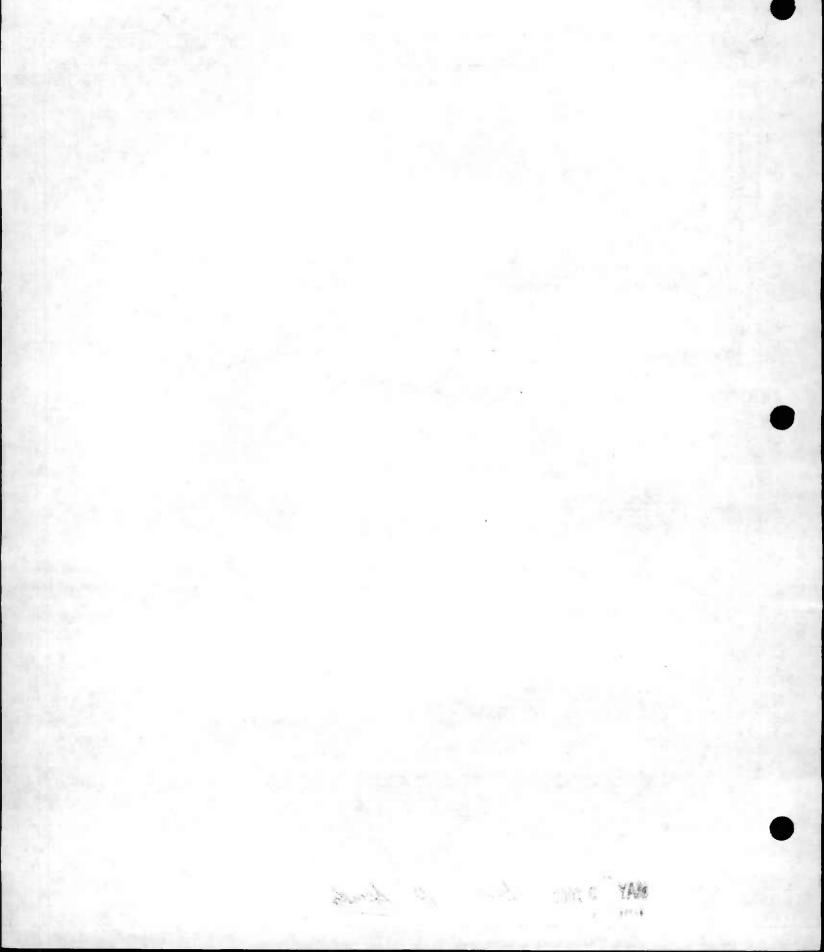


State of Maryland / Department of Health and Mental Hygiene

				ertificate of			Reg. No.	0	4896		
hysician	Decedent's Name (First, Middle, Las	0		C+	affer	2. Dete of De Month	Dey	Yeer	3. Time of Deeth		
Medical	Jolan			3100		May		2000	2245 P.		
xaminer	4e Fecility Neme (If not institution, give	street and number)	11 - 0	11.1	4b. City, Town, o	or Location of Deel	h 4c. County	N/A			
neral	5. Social Security Number 6. Se	7. Age (In	yrs. last birthda	If Under 1 Yea		rs. 8. Date of Bi	ntl I		ce (Stete or For		
ector	184-26-4838	□M 210F 66	Yrs.	Months Deys	s Hours Mi	MAR 24	1934	year) 9. Birthplace (Stete or Country) Hungary			
	Usuel Residence of Decedent  10a. Stete 10b. County	140	c. City, Town or	Lacation							
1 N								10	d. Inside City Lin 1 ☐ Yes 2 🕅		
ect o	PA Cumber	Land	Camp	H1 L L 10f. Zip Code			10g. Citizen of V	What Countr			
iner must be notified Funeral Director	1069 Country C	lub Road		1701			USA	11101 000111	, .		
nera	11. Maritel Stetus	12. Wes Decedent Ever	in U,S. 1	3. Was Decedent of If Yes, specify Cu		(Specify Yes or No		e - Americe			
à à	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		1 ☐ Yes 2 ☐ No		erto Hican, etc.)		k, White, e			
ate de	15. Decedent's Edi (Specify only highest gred	ucetion de completed)	16e. De	cedent's Usual Occive kind of work done  DO NOT use retir	upation e during most of w	vorkina	16b. Kind of Bu	ısiness/Indu	stry		
r, the Medical I	Elementery/Secondery (0-12)	College (1-4or 5+)									
F 0	1.2 17. Fether's Neme (First, Middle, Lest)		Cus	tomer Se	_	eme (First, Middle	CC:				
Be	Kalman Szabo					zabeth		,0)			
To To	19e. Informent's Name/Reletionship (T	ype, Print)	19b. Ma	ailing Address (Stree				Stete, Zip (	Code)		
1 4	Lee Stouffer/Hu			9 Country							
f	20e. Method of Disposition	2	Ob. Plece of Dis	sposition (Neme of rematory or other pl	ace)	Dete	20c. Location -	City or Tow	n, Stete		
10	1 Burial 2 Cremetion 3 1 4 Donetion 5 Other (Specify,			on Societ		5/10/00	Harrisb	urg,	PA		
any injury or other	21. Signature of Funeral Service Licens	600	0.	22 Name end Add Cremati	ress of Facility	ety of	Marvla	nd.	Inc.		
: 5 8	Edward A. Gre	gorehil	es	299 Fre	derick	Rd. Bal	ltimore	. MD	21228		
	23a. Part1. Enter the disease, or comp shock, or heert feilure. List only of	licetions that caused the	death. Do not						Approximete nterval Betwee		
ician									Onset and Dee		
dical niner	Immediate Ceuse (Final disease or condition resulting in death)	a. Int	va ventric	vlar hemo	mhage				days		
- M			to (or es e con:		1				,		
is the burial-trensit		bACI	to (or as e cons	elogenous	leuken	416		i	mont		
EXa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due	to (or as e cons	sequence or):				1			
s the burial-trensit	Cause (Diseese or injury that initieted events	cDue	to (or es e cons	sequence of):	- 10						
23 (0)	resulting in deeth) Last  Due to (or es e consequence of):										
or usa		d									
Physician/M	Pert II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying cause of	given in Pert I.	23b. Did	tobacco uee co	ntribute to	the cause of d		
Ph					1 🗆	Yes 20 No	3 ☐ Prob	Probably 4 Unk			
should be dateched for usa leted by Physician/N						24a Was	en eutopsy	24b. Wer	e eutopsy findi		
shou							ormed?	evei	leble prior to pletion of ceus eeth?		
aga 2						10	Yes 2□No	100	Yes 2 No		
sctor, paga 2 should Be Completed	25. Wes cese referred to medical				26 Place of F	Deeth (Check only			163 215(140		
To B	examiner? 1 Yes 2 No	Hospitel:	2 ER/Outpe	tient 3 DOA	ther.	Home 5 ☐ Res		er (Specity)			
narel	27. Menner of Deeth	28a. Date of Injury (Month, Dey Yea	ar) 28b. Time		ury et ork?	28d. Describe	how injury occur	red	1,100		
lad in by the funare Certification:	1 Naturel 5 Pending 2 Accident Investigation				☐ Yes 2 ☐ No						
tiffe the	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)					281. Location (Street end Number or Rurel Route Number City or Town, State)			
C III											
plately fill edical	29e. Certifier 1√ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my iner: On the basis of exa	y knowledge, de <i>m</i> inetion end/or	ath occurred et the investigetion, in my	time, date end ple opinion, deeth oc	ce, end due to the courred et the time	ceuse(s) and me date end place,	enner es sta and due to	ited. the cause(s)		
Medical Certification: To Be Comp	29b. Signeture end title of certifier	and manner stated.		29c. Lice	nse number		29d. Date signe	d (Month, D	ay, Year)		
()	10/610	4		The Park Inc.	5-000		may (				
A V	30. Neme and eddress of person who c	ompleted cause of death	(Item 23e) (Tur								
7		_			tal In	6 North	lalalfo Cl	reet			
State	John F. de Great, 31. Dete filed (Month, Day, Year)	_	ins Hop	kins Hospi	tal 60	ob North	Wolfe St	reet			

DHMH 16 Rev 6/95

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Data of Death 3 Time of Death **Physician** Cecelia Sheppard May 06 2000 2:30PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1230 Newfield Road Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2☑ F Yrs. Director 213-18-3070 94 Sept. 7,1905 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mentel Hygiene.

ant: If Item 27 is marked other than "natural, or home 23s or 28s-f show my or other traumatic event, the Medical Exeminar must be notified as 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Director Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21207 1230 Newfield Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 31☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk-Typist City Government 10 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) 8 Celia Pauline Hahn J. Edward Tormey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 1230 Newfield Road Baltimore, MD 21207 Benjamin F. Sheppard Jr. (Son) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if Ital eny injury or ott page. th Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/00 Baltimore, MD Loudon Park Cemetery 22. Nama and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner oronar sician end burial-transit The law requires thet the death certificets be axecuted Sequentially list conditions, if arry, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a)consequence of): physician s the burial Box 68760. abetes Due to (or as a consequence of) P.O. I ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably ■ Unknown 1 Yes 2 No Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 28Wo 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was cese refarred to medical examiner? 8 26. Placa of Death (Check only one) Other: 4 Nursing Homa SEResidence 6 Other (Specify) 1 ☐ Yes 2500 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this s 28a. Data of Injury (Month, Day Year) 27. Mannec of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 5 Pending investigation Natural e Hospital or Attending n 24 hours after death. Ne Funerel Director: After pletely filled in by the fur 1 Tyes 2 □ No 2 Accident 28f. Location (Street and Number or Flural Routs Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the To the F

State Registrar 29b. Signature and title of certifie

30. Nama and address of per

Douglas

31. Data filed (Month, Day, Year)

MAY

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2000

sullo, MD

rson who completed cause of death (Item 23a) (Type, Print)

32. Regietrar's Signatura

3421

**DHMH 16 Rev 6/95** 

Benson

29c. License number

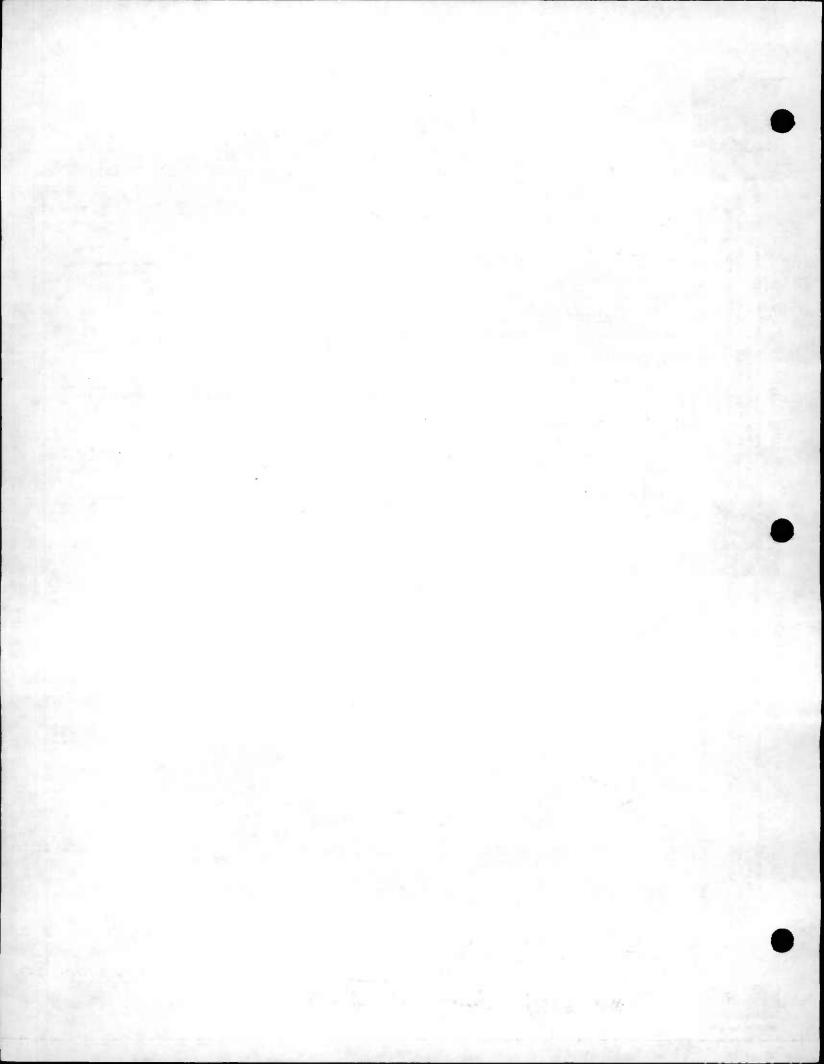
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Suite 230

29d. Data signed, (Month, Day, Year)

00

Baltimore up 21227



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4898 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** PHILIP STE WART May 6130 AM 03 COOS /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL SAMARITAN BALTIMORE 00D 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 24, 1914 N/A5. Social Sacurity Number 6. Sax Birthplaca (Stata or Foreign Country)
 New Jersey **Funeral** 1M M 2□ F 152-10-4964 Director Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ¥ Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 823 Cedarcroft Road Funeral 21212 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status of filed within 72 hours after if Hygiene. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: 3 Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 years Crib Attendant Auto Manufacturing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event DAGS. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Frank Minola Stewart Estelle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Laura Stewart (daughter) 823 Cedarcroft Road Baltimore, Maryland 212.

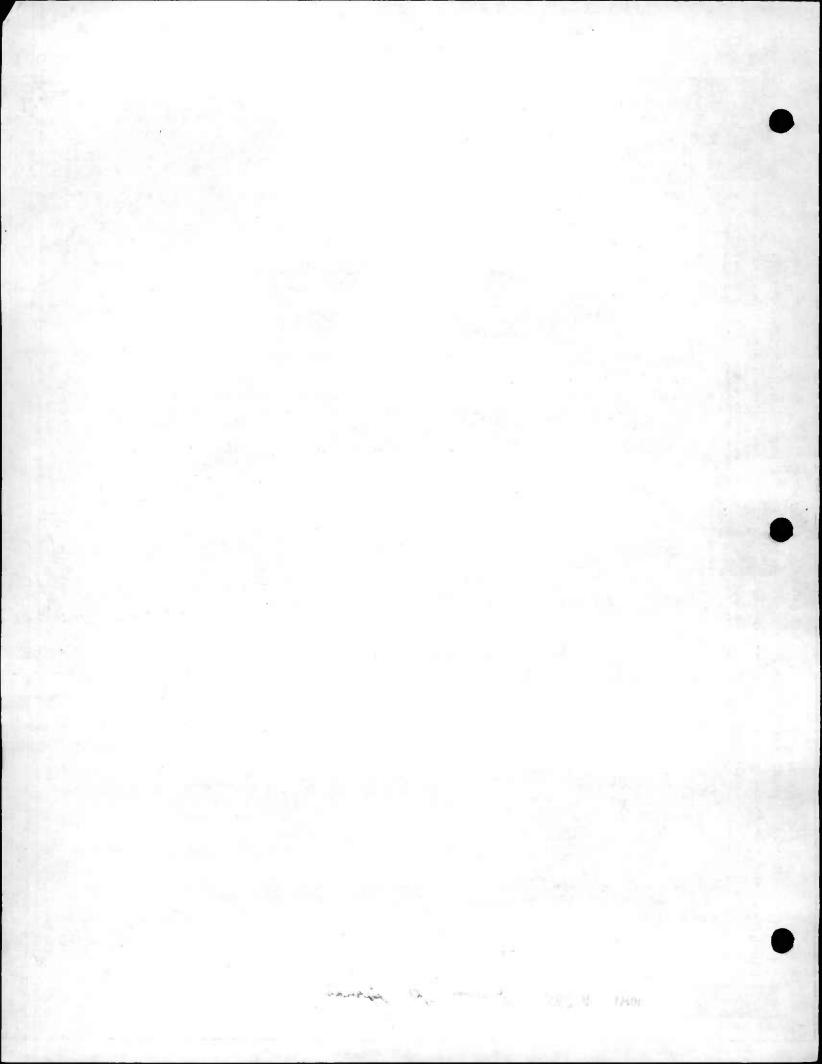
Data 20c. Location - City or Town, Stata 21212 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Removal from Stata 4 Donation 5 DOthar (Specify) Dulaney Valley Memorial Cardens 5-6-2000 Timonium, Maryland 21. Signatura of Funaral Sarvice Licensea 22. Nama and Address of Facility Mitchell-Wiedefeld Funeral Home, 23a. Part1. Entar tha disassa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical CEREBRO VASCULAR Examiner Dua to (or as a consequence of): Physician/Medical Examiner attending physician and for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated exacts.) Myolardial Box 68760 that initiated evants rasulting in death) Last Dua to (or as a consequence of) P.O. 1 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 12 Unknown Records, by 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminar? Hospital: 1 Mnpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifiar 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) evia Negrini MD 03,2000 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Good Sam Hopital - Lock Raven Buld. BAHTMORE MD Negeri MD Year) 32. Registrar's Signatura State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** Kathryn Bryan Stonesifer 0 5 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 800 Southerly Rd. Towson Baltimore 5. Social Security Number 212-38-4958 If Under 1 Yeer | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 94 Director November 18, 1905 Maryland Usual Rasidence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Towson 1 ☐ Yes 2 X No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 800 Southerly Rd. 21286 United States 238 Funeral or Herra 11. Marital Status 12. Wes Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Raca - American Indien, Black, White, etc. 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify Š Specify: white 3 Widowed 4 □ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed withir al Hygiana. other than Elementery/Secondary (0-12) College (1-4or 5+) teacher education Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pegas 1 and 2 should be file Department of Haelth and Mental Hy Important: If itam 27 is marked oth-any injury or other traumatic event 18. Mother's Neme (First, Middla, Maiden Sumame) Be Katie Colbert J. Franklin Bryan 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Ann Carter Stonesifer/dtr.-in-law 3107 Golf Course Rd. W. Owings Mills, MD 21117 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 X Buriel 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem Gard. 5/9/00 Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd 21212 Baltimore, MD 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** tmmediate Ceusa (Final disease or condition resulting in death) /Medical **Examiner** Physiclan/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest attending physician for use as the buris Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? page 2 should Be Completed 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes case referred to medical axeminar? 26. Piece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 ☐ Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA o 28c. Injury et Work? 27. Manner of Dec 28a. Deta of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 Accidant 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) filled in by aftar 4 Homicida Hospital or 24 hours 🛣 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end pleca, end dua to tha causa(s) and mannar as stated. 29a. Certifiar (Check on one) Addical Examiner: On the besis of exeminetion end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated. within 2 To the ŝ 29b. Signature and title of certific 29c. Licensa number 29d. Date signed (Month, Day, Year) Lan 21)00 (Type, Print) bu on 31. Dete fited (Month, Day, State Registrar

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Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Dev Yee Month **Physician** 5 ch wars George mo ' /Medical 4e Fecility Neme (If not institution, give street and number)\_ 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALT 5. Social Security Number Woods 6. Sex BALT If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Funeral Deys Months Hours 100M 20 F 86 Yrs. 212-07-4338 09 18 191 Director Maryland Usual Residence of Decedent death with the Marylend 10b. County 10c. City, Town or Location pernit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "neturel", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examines must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Maryland Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 45 Burke Ave. 21286 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Gas Manufacturing 12 radial drill operator 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Thomas August Schwarz Katie Elizabeth Walper 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Seibert A. Schwarz/son 3686 Double Rock Lane Parkville, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece, 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 M Burial 2 ☐ Cremetion 3 ☐ Removal from State 5/9/00 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery Baltimore, Maryland 22. Name end Address of Facility Mitchell-Wiedefeld Funeral Home, Inc 21. Signature of Funeral Service Licensee 6500 York Rd. nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart failure. List only one cause on each line. 21212 MD Approximete Intervel Between Onset end Death **Physician** cardi compo pathy /Medical Immediate Ceuse (Finel Smoot disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner DISCOR. 3 years Alter physician end s the buriel-transit requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760 Physician/Medical Due to (or es e consequence of) d guipue Po signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause Completed 24e. Wes en eutopsy peen page 2 s 1 Yes 22 No 1 Yes 2 LNo certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 No Investigation 2 Accident 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. edical 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted. 29b. Signature end title of certified 29c. License number 29d. Date signed (Month, Dey, Year) 53720 05 05 00 S 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) S. Rog way, 2112 Belait Rood MD Fallston. P # 2104F 32. Registrar's Signature Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** Bruce Edward Sobota 06 2000 MAY 0150 /Medical 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10950 BEAVER DAM BALTIMORE RD. Hunt Valley If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 213–76–3596 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2□ F Yrs. 43 July 17 1956 Director Maryland Usuel Residence of Decedent with the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Essex Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 811 Norris Lane 21221 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Peges 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene.

int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanic McCormick Spice Co. 12th item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Be Alma J Paugh Charles Henry Sobota P 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Relationship (Type, Print) Winifred Lingelbach / friend 811 Norris Lane Baltimore Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or pnce. Holly Hill Cemetery 5/10 / 2000 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death, shock, or heart failure. List only over chuse on each line. To not enter the mode of dying, such as cerdiac or respiratory arrest, **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical a Hypertensive atheroscleratic Cardiovascular Examine disease Physician/Medical Examine physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as e consequence of) Box 68760. that initiated events resulting in death) Lest Due to (or as a consequence of) 88 980 jo P.O. 23b. Dfd tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Records. þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed has page Yes Yes 2 \ No this certificate of Vital 86 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Medical Certification: To 1XYes 2□ No funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending F Division 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No filled in by tha f 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier O.C.M.E MAY 06,2000

State

Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Itam 38) (Type, Print)

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31. Dele filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** Catherine Savage 4b. City, Town, or Location of Death 6 2000 11:15A.M /Medical 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Genesis Heritage Center Baltimore If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 223-16-3226 Usuel Residence of Decedent 93 10/1/1906 PA 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shor treumstic event, the Medical Examinar must be multified as 1 Yes 2 No Director Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7232 German Hill Rd. 21222 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3. Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pegas 1 and 2 should be filed within 7 Department of Health and Meniel Hyglene. Important: if Item 27 is marked other than "ne any injury or other treumatic event, the Media page. Elementery/Secondery (0-12) Collega (1-4or 5+) Retail Unk. Buyer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Charles Allen Mollie Cox 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Central Ave. Yolanda Dorsey Social Wro Towson MD 21204 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington Laurel, MD 21. Signeture of Funerel Service Lim 22. Neme and Address of Fecility Bradley-Ashton-Matthews Funeral Home, 2134 Willow Spring Rd. MD 21222 Dundalk 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical RATION Examiner Physician/Medical Examiner attending physician end for use es the bunal-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): ALZHEIMERS Box 68760, E that initieted events resulting in death) Last Dua to (or es a consequence of): HYPOTHY ROIDISM P.O. I Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No ANEMIA Records, py 24b. Were autopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? EIZURE DISORDER 210 No 1 ☐ Yes 2 2 No 1 Yes Division of Vitai 25. Wes case refarred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Deeth 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury et Work? 28b. Time of 1 Neturel 5 Pending to Hospital or Attanding in 24 hours after deeth.

The Funeral Director: After pletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edicai

To the within 2

State Registrar

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(Check only one)

29b. Signetura and title of certifier

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30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrer's Signeture

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner steted.

29c. License number

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29d. Date signed (Month, Day, Year)

00-2518-005 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene Unknown 00-107 6903 Certificate of Death John Sullivan 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month Day **Physician** May 04, 2000 JOHN JOSEPH SULLIVAN, IV 7:41 A.M. /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seagate Court and Hopkins Creek Drive Essex Baltimore 8. Data of Birth (Month, Day Year) Aug. 22, 1980 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days Hours Months 1**∑** M 2□ F 19 Director 022-66-8644 Massachusetts Usual Rasidance of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. tnsida City Limits "natural", or items 23a or 28a-f show solical Examiner must be notified at 1 ☐ Yas 2 ▼No Funeral Director Harford Maryland Abingdon 10e. Street and Number 10f Zin Code 10g. Citizan of What Country? 21009 411 Arrow Wood Court USA 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nant of Haalth and Mental Hygiena.
int: If Item 27 is marked other than "natural", or ite 1 ☐ Yas 2 X No If Yes, Give 1) Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 8th grade Never Worked N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be John Joseph Sullivan, III Debra Lincoln 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Department of Health a Important: If Nem 27 Is any Injury or other tra-411 Arrow Wood Court, Jack Sullivan (Father) Abingdon, MD 21009 20b. Place of Disposition (Neme of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 5/8/00 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Schimunek Funeral Home of Bel Air, Inc. mark 610 W. MacPhail Road, Bel Air, MD 21014 Approximata Intervel Between Onsat and Daath 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediata Causa (Fina disaasa or condition rasulting in deeth) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the bunal-trans Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of) 88 usa P.0. ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to complation of ceusa of death? Completed cartificata of Vital 25. Was cesa rafarred to medical axaminar? Be 26. Place of Daeth (Check only one) Hospital: 1 ☐ Inpatiant Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) at scene Medical Certification: To 1X Yas 2□ No 2 ER/Outpetiant 3 DOA this funaral 27. Manner of Death 28b. Tima of Injury 28c. tnjury at Work? 28d. Describe how injury occurred Aftar Division Attending 1 Natural 5 Panding invastigation Found 5/Has of 16 MHz 10 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) daath. 1 Yas 2 Accidant Director: / 3 ☐ Suicida 4 X Homicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) To the Hospital or A within 24 hours aftar To the Funeral Directomplataly filled in by aftar Seazite | Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted complete the cause of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) lay ground 29a. Certifian

Registrar **DHMH 16 Rev 6/95** 

State

29b. Signatura and title of certifier

31. Data filed (Month

THEODORE MIKE

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32. Registrar's Signatura

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

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29c. Licanse number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

May 05, 2000

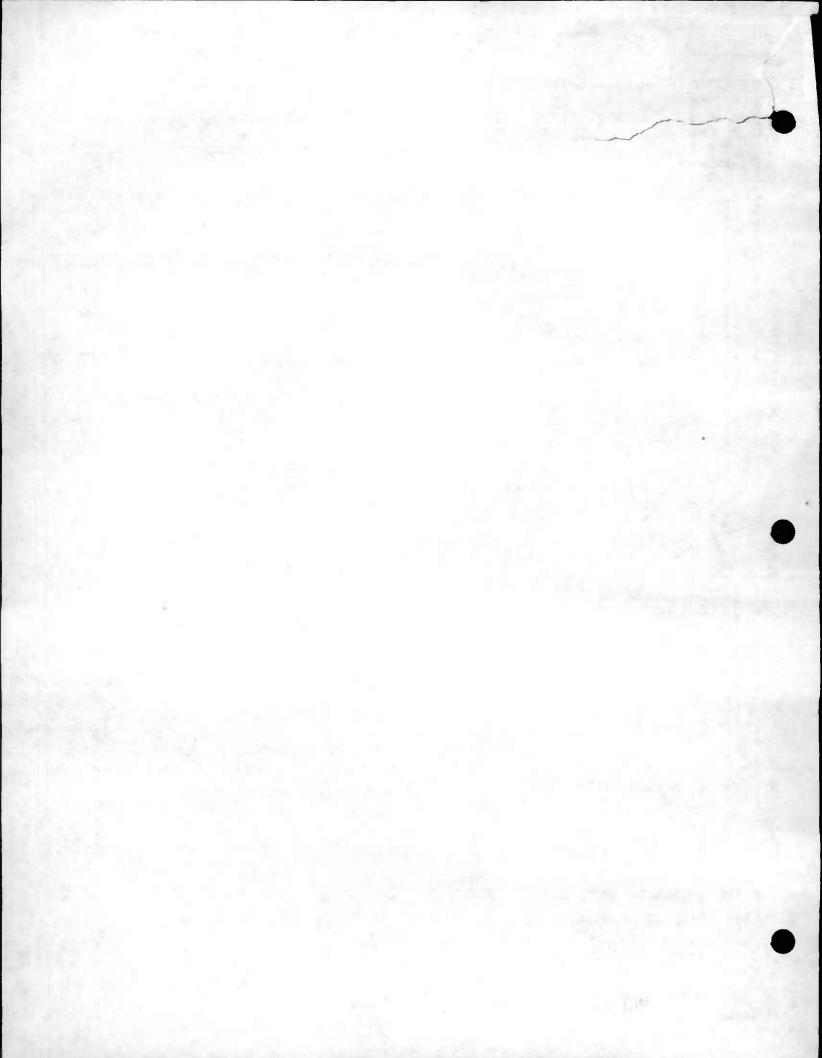
The second of th All Street Sugar Street

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 00:2395-510 State of Maryland / Department of Health and Mental Hygiene Patricia Smith AMEND ITEMS: #23 PART I, II, 27, 28A-F PER CENTIFICATE OF DEATH JVW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Patricia Ruth Smith April 30,2000 3:44 P.M. /Medical 48 Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Agres Hospital Baltimore If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 M 2 TF 218-78-5099 Yrs. Director Oct 18, 1958 41 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits rai", or itama 23a or 26a-f ahov Examiner must be notified at ©Yes 2 No Directo Maryland Baltimore n/a 10a. Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 2617 Wilkens Avenue 21223 U.S.A. Funeral daath 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: hours after 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: P 3 ☐ Widowed 4 ☑ Divorced natural', Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) filed within 72 h Hygiene. other than \*natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Industrial Engineering 12 0 Designer permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if Nem 27 is marked oths any liny or other traumatic avant. Potes. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert S. Smith, Sr. Dorothy Ruth Smith (Short) 2 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Wilkens Avenue, Baltimore, Maryland 21223
Disposition (Name of Date 20c. Location - City or Town, State Robert S. Smith, Sr. 20b. Placa of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/4/2000 Glen Burnie, Maryland Glen Haven Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23e. Perti Enter the disease, or complications het caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one datum on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Finel NARCOTIC INTOXICATION diseese or condition resulting in death) Examine Due to (or es a consequence of) Examiner certificate be axecuted physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in listed events.) Due to (or es a consequence ot): Box 68760. Physician/Medical that initieted events resulting in death) Lest Due to (or es e consequence of): 98 23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. o 1 ☐ Yes 2 ☐ No 3 Probably 4 MUnknown 0 COCAINE USE Records, by 24b. Were autopsy findings available proc to completion of cause 24a. Wes en eutopsy performed? Completed pege 2 has 1 Yes 2 No TINYes 2 No cartificate of Vital Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ P/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1º Yes 2□ No 28e. Dete of Injury FOUND: 28b. Time of P 27. Menner of Deeth 28d. Describe how injury occurred 28c. tnjury et Work? edical Certification: After Division Attanding 5 Pending investigation FOUND: 3:00 1 Neturel UNKNOWN aftar deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 4-30-00 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2617 WILKENS AVE. 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) or A 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in FOUND AT HOME BALTO. CITY, MD. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) title of certifier O.C.M.E. May 1,2000 ss of person who completed seuse of death (Item 23e) (Type, Print) 30. Neme and addr es tane 0 111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signetur 9 2000 31. Dete fil State Registrar **DHMH 16 Rev 6/95** 

ORIGINAL



Wease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Physician Month 9:18 AK MARY ANN SWEENEY 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner STELLA MARIS HOSPICE AT MERCY BALTIMORE N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Dala of Birth (Month, Day, Year) **Funeral** 1□M 210 F Days 86 Yrs. Director 191-12-5556 Oct.10 1913 Penna Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. No Yas 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1414 Riverside Ave. 21230 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Henn any Injury or other traumatic avant, the Medical Exercises page. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: þ Specify: white 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Harbor Hospital Registered Nurse 12 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) å John Mundy Mary Redmond 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 1409 Riverside Ave. Baltimore, Md. 21230 De of Disposition (Nama of Data 20c. Location - City or Town, Stata Mary A. Windsor (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion ☐ Other (Specify) 5/09/2000 Green Mount Cemetery Baltimore, Md 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility McCully-Polyniak Funeral Home P.A. Ces 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or raspiratory arrast, shock, or heart feilura. List only one cause on each line. Approximete tntarval Batween Onsat and Daath Physician Immediata Cause (Final disease or condition resulting in death) /Medical Cance Examiner Dua to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No B 25. Was casa referred to medical axaminer? 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance Sonther (Specify) Medical Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? 28b. Time of 1 ☑ Natural 2 ☐ Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

 Hospital or Attanding Physician: The law requires that the death certificate be associted
24 hours afterdeeth.
 Funeral Director: After this certificate has been signed by the attending physician and
ietely filled in by the funeral director, pege 2 should be detached for use as the burlat-transit P.O. Box 68760, Records, Division of Vitai

28a-f ahon

r then "natural", or itema 23a or 28a-f ahor the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

To the Hosp within 24 hos To the Fune completely fi

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es steted.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifier

4 Homicide

31. Data filed (Month,

29a. Certifier

29c. License number M

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29d. Data signad (Month, Day, Year) 2000

Bultwore

21503

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

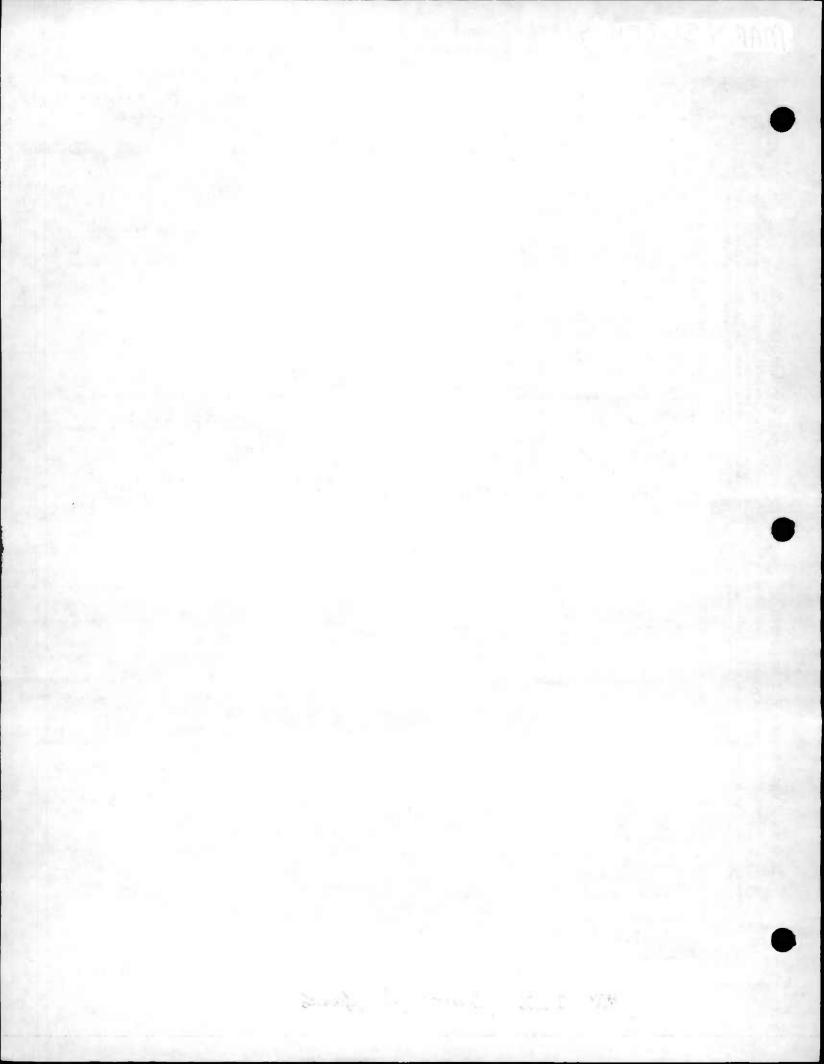
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Rischery, MD 32. Registrar's Signatura 2000

Paul PI St 301

State

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 14906 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year CATHERINE ANNA SOBUS MAY 2000 11:27 A.M. 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death GILCHREST TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Deys 1 M 2 TF Yrs. 212-34-5675 1/30/36 MARYLAND **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD 1 ☐ Yes 2√ No HILLENDALE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 8318 HILLENDALE ROAD USA 21234 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2☑ Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH GRADE CLERK CLERICAL 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD KEENE PAULINE ALLARD 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) THEODORE F. SOBUS HUSBAND 8318 HILLENDALE ROAD HILLENDALE, MD 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) STANISLAUS CEM. 5/8/2000 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximeta totarvel Between Onset end Death ert1. Enter the disease, or complications thet caused the daeth. Do not en shock, or heart tailure. List only one cause on aach lina. Immediate Cause (Finat disease or condition resulting in death) 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of): that initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 10501CC 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 50 Natural 5 Pending investigation 1 Yas 2 No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

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after death. 8 To the Hospital within 24 hours a To the Funeral C

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Certification:

29a. Certifier (Check only one)

29b. Signature and title of certifie

**⊮**Physician

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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filed within 7 Hyglene. 2ther than "n ent, the Med

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oths any Injury or other traumatic event.

Physician

Examiner

Registrar

**DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year) MAY 2000

Game 6701 32. Registrar's Signeture

ted cause of death, tem 23a) (Type, Print)

chales St. Balto Md 21204

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

025205

29d. Date signed (Month, Dey, Year)

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#### Please Type or Print in Black Indelibie ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Spence : OSpin inda Mai 2000 10 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore lite N/A HOS Hopkins ns Hospi 7. Age (In yrs. last birthday) tal Johns If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number If Under 1 Yeer 6. Sex Birthplece (State or Foreign Country) Days Months 1 M 2 F 50 9/13/1949 Maryland 218-54-4373 Usuel Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Baltimore Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3322 Willoughby Road 21234 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Raca - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Administrative Assisant 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Kelly Thomas M. Mulgrew Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Willoughby Rd. Baltimore, Md. 21234 John Spence- Husband 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 □XBurial 2 □ Cremetion 3 □ Removal from Stete 5/10/2000 Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Leonard J. Ruck Funeral Home Dary R. Di Giovanne 5305 Harford Rd. Baltimore, Md 21214 Gary R. DiGiovanni 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final one month disease or condition resulting in death) one Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 2000 1 ☐ Yes 2 300 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Apatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27 Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 2 Accident

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

, or items 23s or 28s-f show

Director

Funeral

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Completed

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permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental hygiene. Important: if New 72 I a marked other than "natural", or itema 23a or 28a-f ahon any injury or other traumatic event, the Medical Experient ment or notified as in yinjury or other traumatic event, the Medical Experient ment or notified as

Baltimore, Maryland 21215-0020

Box 68760

with the Maryland

Examiner burial-transit physician Physician/Medical signed by the attending physid be detached for use as the þ been sign Completed Be To funeral Certification: After

The law requires that the death certificate be executed Division of Vital Records, P.O. or Attending Physician: s after death.

If Director: Af
ed in by the fu filled in by To the Hospital within 24 hours of the Funeral formpletely filled Hospital

> State Registrar

edical

Johns Hopkins Hospital, Tower 110 Doctors 31. Dete filed (Month

5 Pending Investigation

6 Could not be determined

3 ☐ Suicide

29a. Certifier (Check only

4 Homicide

29b. Signeture and title of Certifie.

32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

1 Tyes 2 No

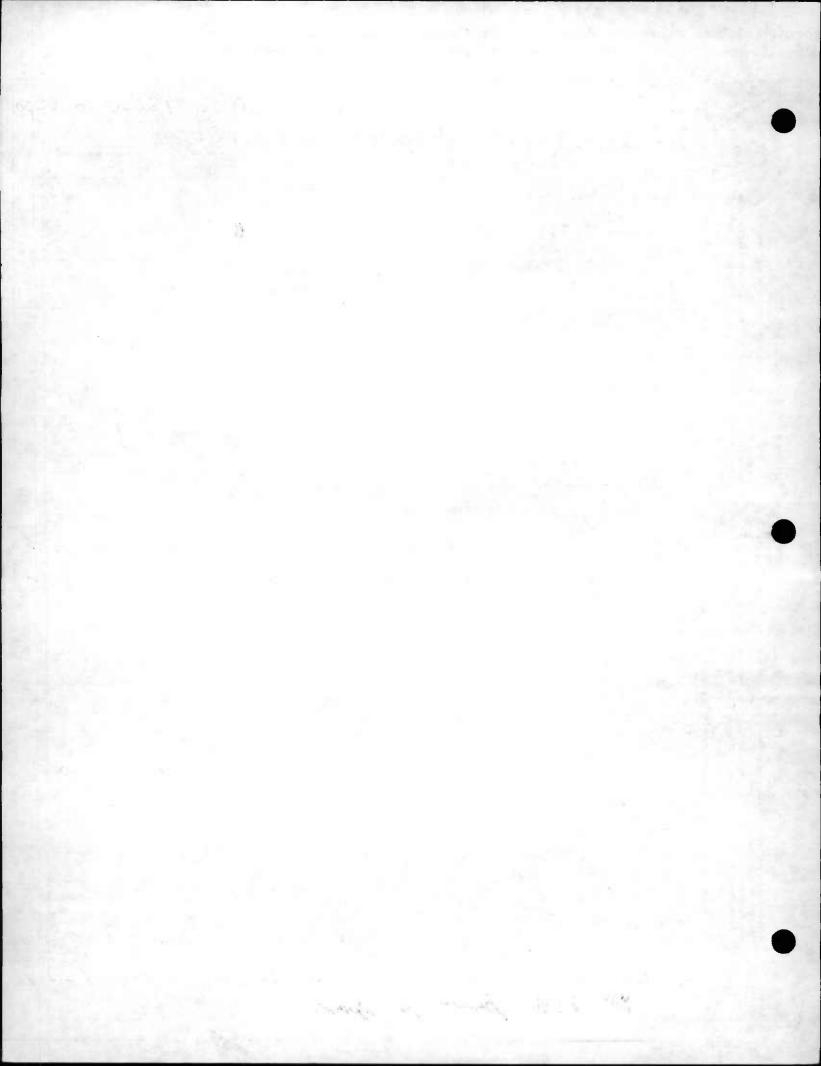
Descritifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Large, 600 North welfe street, Baltimore, Maryland 21287

**DHMH 16 Rev 6/95** 



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month May 5, 2000 3;03 P.M. CATHERINE A. SAYBOLT 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 12223 Faulkner Drive Mills Baltimore If Under 1 Yeer 9. Birthpleca (Stete or Foreign Country) Penna 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Months Deys Hours 10M 20F Yrs. 86 157-38-1024 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Md. Baltimore Owings Mills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21117 USA 12223 Faulkner Drive 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2√☐ No Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Clerk U.S. Post Office 12 Grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Dunn Mary Delaney Harry Dunn 19a. tnforment's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Kathleen A. Birtwistle Owings Mills, Md. 21117 12223 Faulkner Drive 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State Pitman N.J. Hill Crest Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 5/9/00 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Md.21136 ine 23e Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) Supra vertini TAcly condu Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pertension Que to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 2000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 40 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation

The law requires that the death certificate be executed of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23s or 28s-f show

Funeral Director

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Completed

Be

2

Examiner

Physician/Medical

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Completed

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Medical Certification: To

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Hasith and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show entry injury or other traumatic event, the Medical Examiner must be notified at ORGE.

Physician

/Medical Examiner

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Maryland 21215-0020

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has this certificate or Attending P Division ours after death. weal Director: Aft filled in by the fur To the Hospital within 24 hours a To the Funeral C

funeral

State Registrar

ainters 31. Dete filed (Month, Dey, Year)

29b. Signaldre and title of certifie

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

29c. License number 0

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

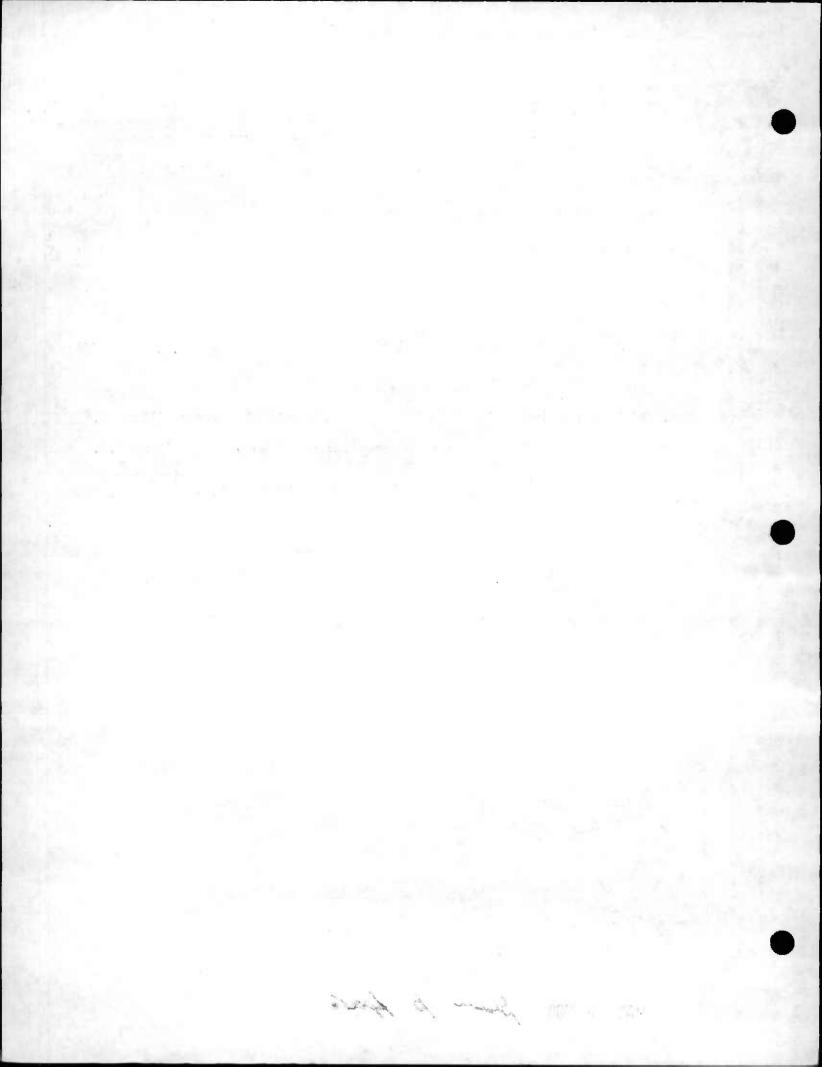
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 5.ke

6 Could not be determined

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

32. Registrer's Signeture 9 2000



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	tem 24a per phys. G783  1. Decedent's Name (First, Middle, Las		Reg. No. 2. Date of Death 3. Time of Death								
nysician Medical	WILLIAM SHARP							Month Day Year 7-05			
kaminer	4a Facility Name (If not institution, give					**	ocation of Deat	th 4c. County			
	CATONSVILLE  5. Social Security Number 6. So		(In yrs. last birt	nday) If Under 1	Year If L	ATD NS	VILLE	E BA	LTIMORE  O Bithplace (State or Foreign		
eral : ctor	202/03/66			rs. Months	Days H	ours Min.	8. Date of Bi (Month, Do Apr 28	, 1920	Birthplace (State or Foreign Country)     PA		
	Usual Residence of Decedent  10s. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
ģ	MD Baltimo			1 □ Yas 2 No							
Si Si	10e. Street and Number 10f. Zip Code							10g. Citizen of N			
r tems 23a or 28a-fa olner must be notified Funeral Director	16 Fursting Avenu				2122			U.S.A			
þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was Decede If Yes, specif			Decity Yes of No Dican, etc.)	Specify	e - American Indian, :k, White, etc. : white		
eted	15. Decedent's Ed (Specify only highest grad			Decedent's Usuel (Give kind of work	done durino	most of won	king	16b. Kind of Bu	iness/Industry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+						fod	eral govt		
Be C	17. Fether's Neme (First, Middle, Last)	none		dir		Mother's Nam	ne (First, Middle	, Maiden Suman			
Department of Health and Mental Hygiene mportant: If item 27 is marked other the any injury or other traumatic event, the page.  To Be Com	John J. Shar						cian M. Koren				
	19a. Informant's Name/Relationship (7) Catonsville Comm			Mailing Address ( 16 Furst			rai Route Numb	per, City or Town,	Stete, Zip Code)		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removel from State	20b. Place of	Disposition (Neme r, crematory or oth	B of	Vende	Date	20c. Location -	20c. Location - City or Town, State		
9900	4 ☑ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee Ronald S. Wade, Director  22. Nama and Addrass of Facility State Anatomy Boa Baltimore, MD 21							ard 655 W. Baltimore Street			
n al	23a. Fartt. Enter the dinedse, of compensors, or heart tellure. List only of the condition resulting in death)	olications thet caused to one cause on each line	he death. Do n	or enter the mode		ch as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death		
. 1	resulting in death)	D	ue to (or as a c	onsequence of):			- 72		z-3 days		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b	ue to (or as a co	to (or as a consequence of):					3-6 days		
edical	Cause (Disease or injury that initiated events resulting in death) Last	d	ue to (or as a co	onsequence of):							
Iclan	Part II Other eignificant conditions or	patributing to doub but	ributing to death but not resulting in the underlying cause given in Part I					23b. Did tobacco use contribute to the cause of death?			
y Phys		dementia, Acute CVA,						1 Yes 25(No 3 Probably 4 Unkno			
Completed by Physician/M	Diabetes, ter	portener					perf	s an autopsy ormed?	24b. Were eutopsy findings available prior to completion of cause of death?		
Co	Chronic Rone	d Failre	Ische	emic He	out ]	Sease	- 10	Yes 2 No	1 ☐ Yes 2 ☐ No		
å	25. Was case referred to medical examiner?	Hospital:			Othor		th (Check only				
within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page  Medical Certification: To Be Com	27. Manner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	1   Inpatient 2   EH/Outpatient 3   DOA   4   ANursing Home						ne 5 Residence 6 Other (Specify)  8d. Describe how injury occurred		
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
edical	29a. Certifier (Check only one)	rsician: To the best of iner: On the basis of e and manner state	xamination end	death occurred at /or investigation, i	t the time, do n my opinion	ate and place n, death occu	, end due to the rred at the time,	cause(s) end me date and place,	enner as stated. and due to the cause(s)		
<b>X</b>	29b. Signature and title of pertifier  Coldron Rey		29c	License nur 275			29d, Date signed (Month, Day, Year)  April 22, 2000  [Himore, MD-21227]				

DHMH 16 Rev 6/95

The state of the s

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month APRIL 28, 2000 LEONARD A. SCHUTTIG 6:35 PM 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) MONTGOMERY VILLAGE CARE & REHAB MONTGOMERY GAITHERSBURG If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) Deys 1**X** M 2□ F Yrs 578-03-5428 93 Oct 15, 1906 N.T Usuel Residence of Decedent 10e. Stete MD 10c. City, Town or Location 10d. inside City Limits Montgomery Gaithersburg 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 19301 Watkins Mill Rd USA ce - American Indian, 20879 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14 Race Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) electrical engineer electronics 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Schuttig Anne M. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Len Schuttig Jr/son 20b. Place of Disposition (Name of cemetery, cremetory or other place)

20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 Donetion 5 Other (Specify) Mine of Funguel Service Licensee Ronald S. Wade Direct 22. Name end Address of Fecility
State Anatomy Board Director 655 W. Baltimore Street Baltimore, MD 21201 att. Entur the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, ock, or heart takers. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) chronic regal one yo Due to (or as e consequence of): 20455 hypertans, 8 Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown Al Thermers 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy 1 Yes 2 No 1 □ Yes 2 P No

Physician Examiner Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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**Funeral** 

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pemit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "natural", or items 23e or 28a-f show any highry or other traumatic event, the Medical Expurient must be notified at once.

altimore, Maryland 21215-0020

physician and s the burial-tran the attending p use as signed by the sid be datached to been has page 2 cartificate this

Physician/Medical

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Certification: To

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29a. Certifier

raquires that the death certificate be axecuted or Attending Physician: funeral director, After after daath. Hospital of 24 hours a Funerel D

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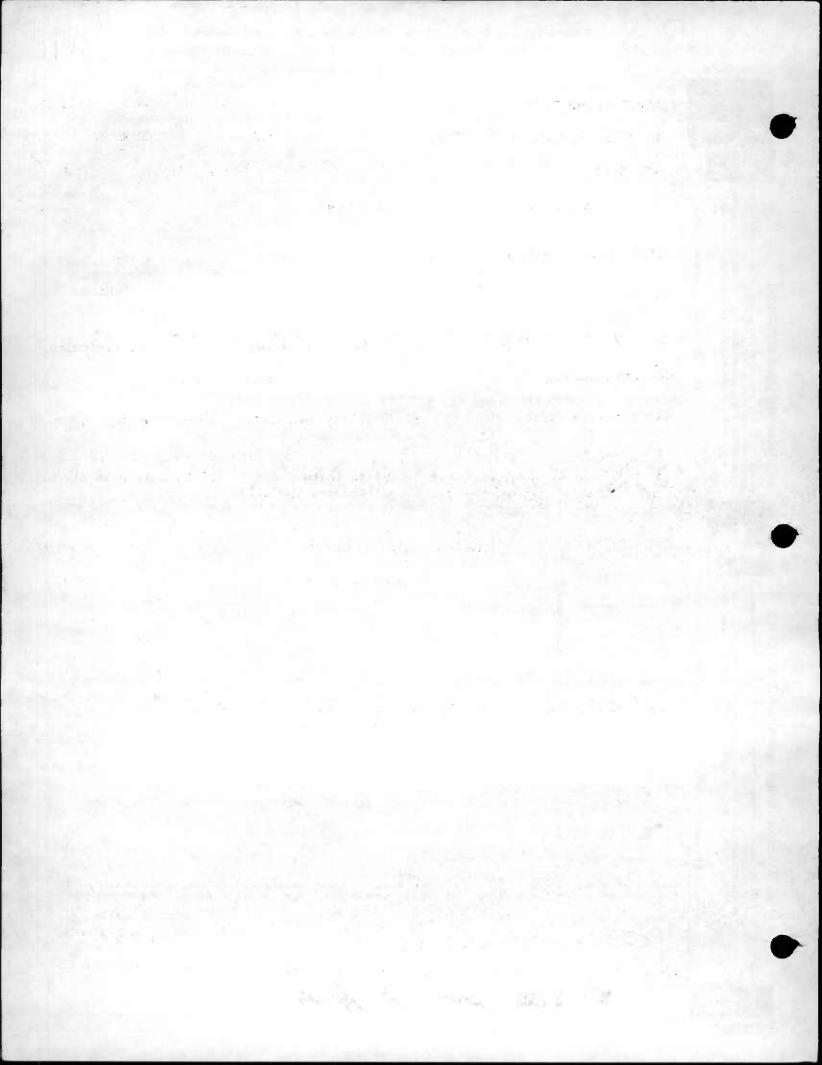
Registrar

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 46 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide 🗺 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) May 03, 2000 D33443 e cheece mo 809 Vies Mill Rd. Rockrille, md 20851 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Alan R. Pollack, M.D. 32. Register's Signature

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To the Hosp within 24 hor To the Fune completaly fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 49 Certificate of Death AMEND#20B PER F.H. G783 5-9-200 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month LAURA 11:44 pm SCHENK MAY 2000 5 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Daath 4c. County of Death NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Undar 1 Yaar 8. Data of Birth (Month, Day, Yaar) AUG 17 1913 Birthplaca (Stata or Foraign Country)
 NEW JERSEY 5. Social Sacurity Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2X F 86 137-01-9861 Yrs Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD BALTIMORE 1 ☐ Yas 2 ☑ No BALTIMORE 10e. Straat and Number 10f. Zip Code 10g. Citizan of What Country? 16 OLD COURT ROAD 21208 USA 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 □ Never Married 2 □ Married 1 Yas 2 No If Yas, Giva Yaar or Datas: 1□ Yas 2□No Spacify. SpecWHITE 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) BOOKKEEPER AIR CONDITIONING 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) WILLIAM KAY MARY ROMANOFF 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code)
NORTH 19a. Informant's Name/Relationship (Type, Print) 5811 EDSON LANE #203 BETHESDA, MD.

20b. Place of Disposition (Name of camatary, cramatory or other place)

MAY 0ate 20c. Local MAY 2000 MARJORIE SCHENK/DAUGHTER 20852 MAY 7, 2000 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) ARLINGTON-CHIZUK AMUNO MAY 72000 BALTIMORE, MD. CONGREGATION 22. Name and Address of Facility 21. Signature of Funeral Service Li SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part1. Entar the discrete or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onset and Daath Ischemie Immediate Causa (Final diseasa or condition resulting in death) Due to (or as a consequence of): Dua to (or as a consaquance of) Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed' 2 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Dipatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

"natural", or items 23a or 28a-f ehow solical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumetic event, the Molicel Exert extra

Baltimore, Maryland 21215-0020

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ed by the ettending physicien end deteched for use as the buriel-trensit The lew requires that the death certificate be executed signed b page 2 s Is certificate h this After this funeral of

Division of Vital Records, P.O. Box 68760, or Attanding Physician: death. d in by the efter

within 24 hours of To the Funeral Di completely filled in Hospital To the Within 2

> State Registrar

30. Name and address of

31. Data filed (Month, Vy, Year)

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Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiate cause. Entar Undarlying Causa (Diseasa or injury that initiated events rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. þ Completed Be 25. Was case refarred to medical axaminer? P 1 Yas 2 No 28c. Injury at Work? Data of Injury (Month, Day Yaar) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) end mennar stated. edicai 29a. Certifier (Check only 2 Medical one) 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of Del my Ma 2000

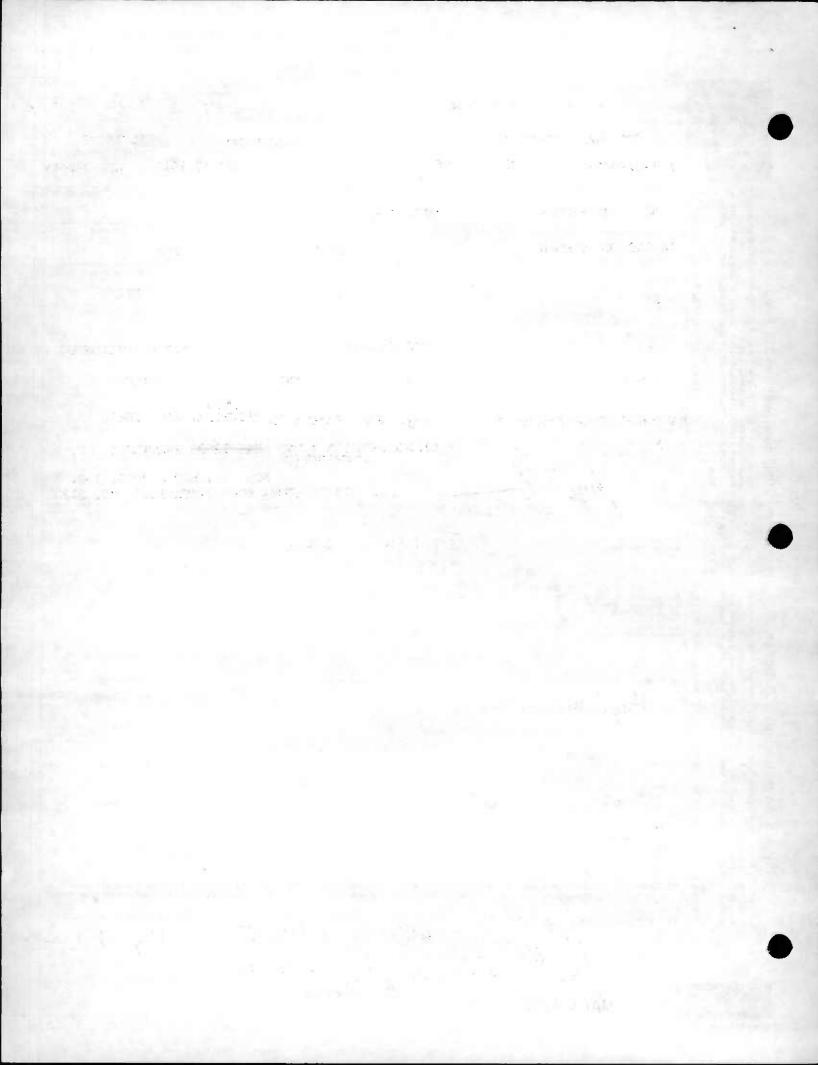
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erson who sympleted ceuse of death (Itam 23a) (Type, Print)

32. Registrar's Signature

IMPERIAZ

2000



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14912 Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 6,2000 nay 17 AM MARTIN 1 OWNS LEY JOSEPH 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Center 1 Yaar Hospital Franklin Square 5. Social Security Number 6. Sax Osedale Balti more 7. Aga (In yrs. last birthday) If Under Months If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 12M 20 F Yrs. 219-12-6842 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐-No MD BALTIMOBE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 3735 JOPPA 21236 RD 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE NAVY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MARYLAND Elementary/Secondary (0-12) College (1-4or 5+) MOIMU PIZESIDENT TEAMSTERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) TOWNSLEY MC CLUBE ROBERT STAULBITZ LEONA CATHERINE 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) E 3735 E. JOPPA RD. 20b. Place of Disposition (Name of cemetary, cremetary or other place) ST. JOHN'S LUTHERAW MA PERRY HALL, MD. 21236 Date 20c. Location - City or Town, State ALMA TOWNSLEY SPOUSE MAY 9 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2-000 PARKVILLE CHURCH 21. Signature of Funeral Service Licanses EVANS FUNDEAL CHAPEL PARKVILLE, MD. 21234 8800 HARFORD RD. 23a. Part Enter the disease or shock, or haart feilure. List or man accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Arrythmia Cardiac 15 Minutes diseese or condition resulting in death) Atlerosclerosis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco was contributa to the causa of death? Diabetes Mellitus - Type 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Finpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

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Funeral

Completed

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**Funeral** 

Director

al Hygiene. other than "natural", or learn 23a or went, the Medical Examiner must be.

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Pages 1 and 2 should

altimore,

Box 68760.

P.O.

should be find Mental Financed of

Department of Health and M Important: If Item 27 is man any injury or other traumati

Examiner sician and burial-transit Physician/Medicai USB Completed by Be edical Certification: To this After

s after death.
I Director: Aft
od in by the fur

of Vital Records, Physician: Division or Attending To the Hospital of within 24 hours at To the Funeral D Completely filled i

Registrar

29b. Signature and title of con-

28a. Dete of Injury (Month, Dey Year)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medicat Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year)

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28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Suter 9000 Franklin Square Drive Baltimore, MD21237 Dr. Michael

(Month, Day, Year)

5 Pending

investigation

6 Could not be determined

27. Menner of Death

1 Natural

2 Accident

3 ☐ Suicide

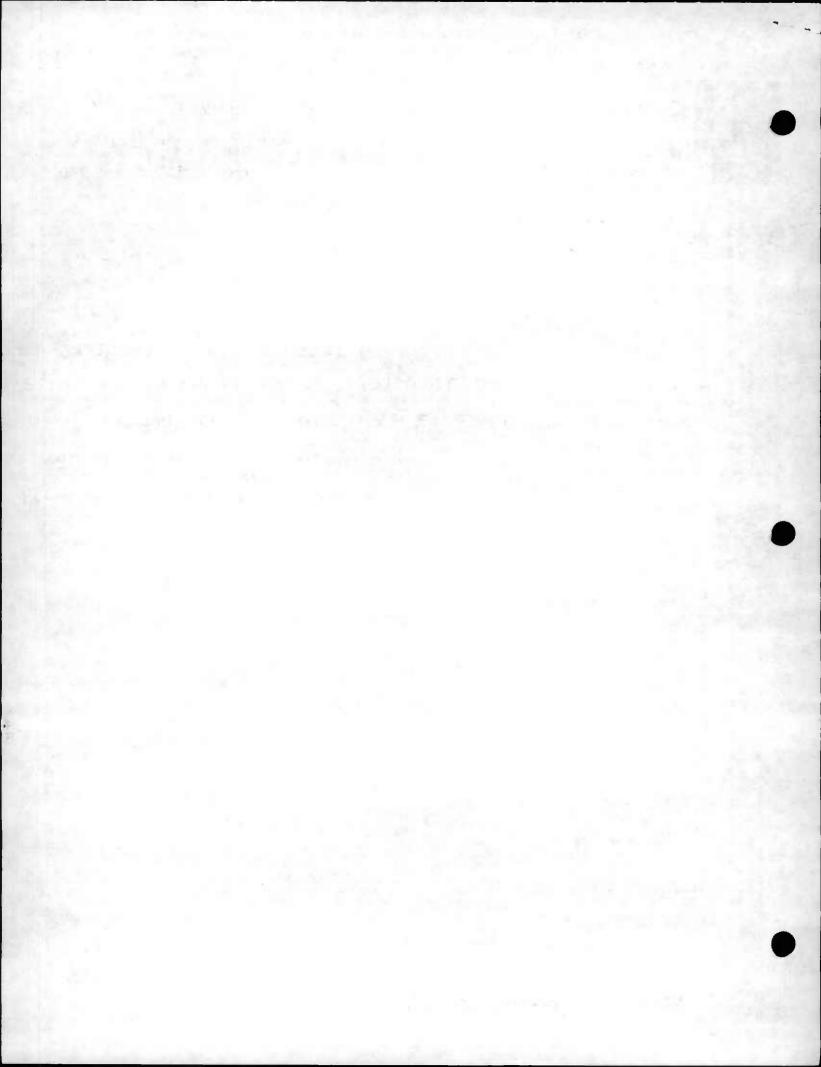
29a. Certifier (Check only one)

4 Homicide

32. Registrar's 6ignatura

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



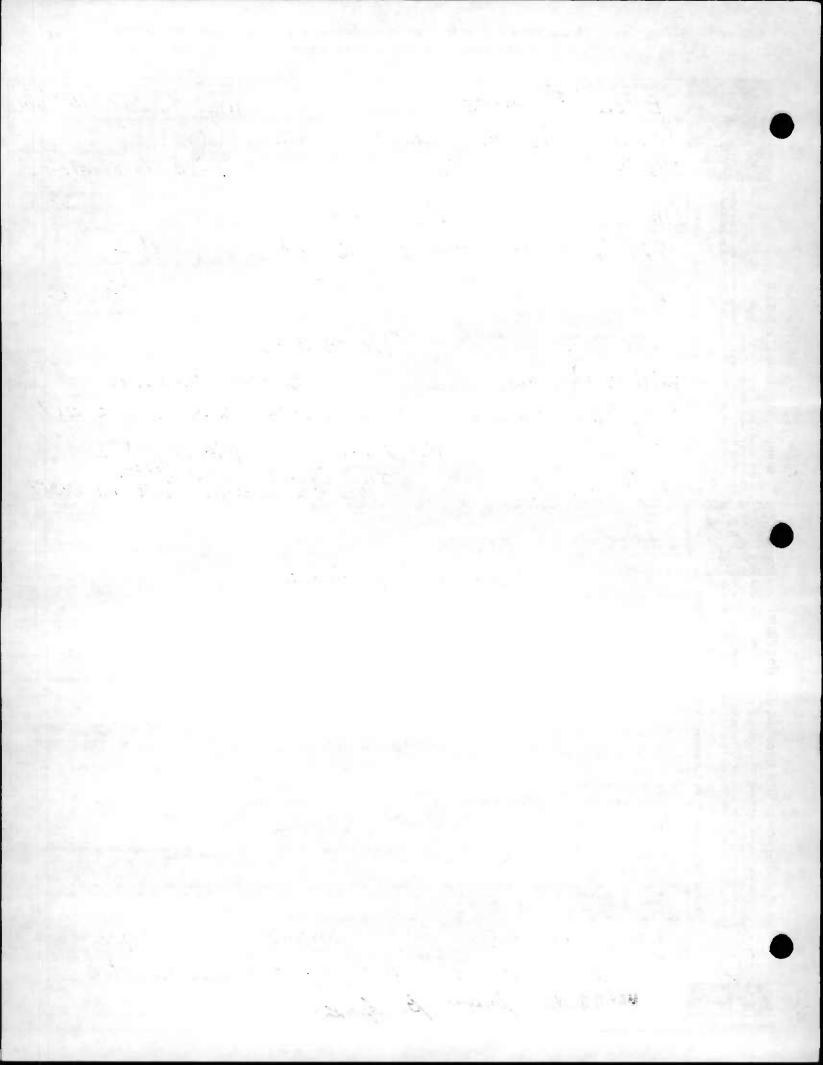
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** immons /Medical 4a Facility Name (If not institution, give street and number 4d. County of Deeth 4b-Sity, Town, or Local Examiner land 7. Age (In yrs. last birthday)
Yrs. If Under 1 78-28 Birthplace (State or Foreign Country) **Funeral** 481 1 M 2 H irginia **Director** Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or flems 23e or 28e-f sho traumetic event, the Medical Examiner must be notified at 1 Tes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1824 11. Marital Status 4.5 2/2/ Funeral Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Newer Married 2 ☐ Married 1 Yes 2 DNo If Yes, Give Year or Dates: 1 mmmons 1 Yes 2 No Specify by 3 Widowed 4 □ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LInknown Stic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 phia 2 Willie 710300C Pages 1 and 2 should 50 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1834 W. North 21217 Dalto MD 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8 8/10/00 1 Deurial 2 Cremation 3 ☐Removel from State b Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility

Trvin Carrol 21. Signeture of Funeral Service Licenses W. North Balto. MD 2/2/1 Approximate Interval Between Onset end Deeth 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PSIS Examiner Due to (or as a consequence of): Physician/Medical Examiner ragn attending physician and for use as the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequenca of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate hes been sit completely filled in by the funeral director, page 2 should to the funeral director, page 2 should to the funeral director. 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 12 Certifying Phyelclan: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number Soumai 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) nalyan 31. Date filed (Month, Day, Year) MAY 0 9 2000 32 Registrer's Signature State Registrar

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

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cian Iical	Thomas Monroe Tongue									May	7	2000	2:10	A.M.
iner		4e Facility Neme (If not institution, give street and number)								ocation of Deeth		nty of Death		
1	Manorcar  5. Sociel Security (		Cau 7	A ma //m . ma	land biothda.	) If Under	1 Vear	Tow		9 Date of Bird		altimo		
	216-01-2 Usuel Residence of	228	Sex 1 M 2□ F	Age (In yrs. 88	Yrs.	Months	Deys		Min.	8. Date of Bird (Month, Da May 16	2000	Y. Birting Cour MD .	place (State ontry)	or Foreign
miner must be notified at y Funeral Director	10e. Stete	10b. County		10c. Cit	y, Town or L	ocation		100				1	0d. Insida C	City Limits
	Md.	Baltin	nore		Phoer	nix							1 🗆 Yes	2 15 No
3	10e. Street and Nu					10f. Zip	Code			- 1 0	10g. Citizen	of Whet Cour	ntry?	
Funeral D	2290 Me	rrymans	Mill RD.				211	.31	USA					
	11. Maritel Stetus 1 ☐ Never Men 3 🌃 Widowed	ried 2 Married	12. Wes Decede Armed Force 1  Yes 2 If Yes, Give Yeer or Dete	s? XNo	S. 13.	Wes Deced If Yes, spec	cify Cub	oen, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		lace - Americ leck, White, city: Wh		
ŀ	(Spe	15. Decedent's E			16e. Dece	dent's Usua	al Occu	petion	t of work	rina	16b. Kind of	Business/In-	dustry	
ŀ	Elementery/Sec		College (1-4c	or 5+)	lifa.	DO NOT us	se retire	during mos	or work	y				
			1+		Assis	stant	VP			se Sup.				
	17. Fether's Name									e (First, Middle,				
		abb Tongu							_	Elizab				
		leme/Relationship M. Tongue						et and Numbe	er or Rur	al Route Number	er, City or Tov	vn, State, Zip	Code)	
	20e. Method of Dis 1 Burial 2 4 Donation		leca of Disp emetery, cre odlawi	matory or o	ther pla	ace) Y	0	Deta 5/10						
21. Signeture of Funeral Service Licansee  Sterling Ashton Schwab Funeral Home, Inc. 736 Edmonsdon Ave. Baltimore, MD. 21228														
	Sequentially list of if eny, leeding to it cause. Entar Und Cause (Disease of thet indicated event resulting in death)	onditions, mmediate erlying r injury s	b	Due to (o	r es e conse	quenca of):						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(0).
	Pert II. Other signi	ert II. Other significant conditions contributing to death but not resulting in the underlying ca						iven in Part I	).	23b. Did tobacco use contribute to the cause of				
page 2 should be detached for us.  Completed by Physician/					Ä					24a. Wes	en eutopsy ormed?	94	ere eutopsy eilable prior empletion of deeth?	to
										10	Yes 2 No	1	Yes 2	□ No
00	25. Wes casa rafa	rred to medicat						26. Place	a of Daat	th (Chack only o	ona)			
0	axaminar?	No.	Hospital:	atient 2	ER/Outpetie	nt 3 DC	DA O	thar: 4 N	ursing Ho	ome 5 Resi	denca 6 □0	Other (Speci	(y)	
cel tillcation.	27. Mannar of Dea Neturel 2 Accident	5 Pending Investigation		njury Day Year)	28b. Time of Injury	of 2	28c. Inju Wo 1	ury et ork? Yes 2	No	28d. Describe	how injury oc	curred		
	3 Suicide 4 Homicide	6 Could not l								mber,				
10000	29a. Cartifier (Check only one)	Certifying P	hysician: To the be miner: On the basis end menner	of exemine	wledge, deet tion and/or in	th occurred nvestigation	et the t	time, date er opinion, dae	nd plece, oth occur	end due to tha red et tha time,	causa(s) and data end pled	manner es s ce, end due t	teted. o the ceuse(	(s)
M	29b. Signeture and	Ditle of certifier	/			290	29c. License number				29d. Date signed (Month, Dey, Year)			
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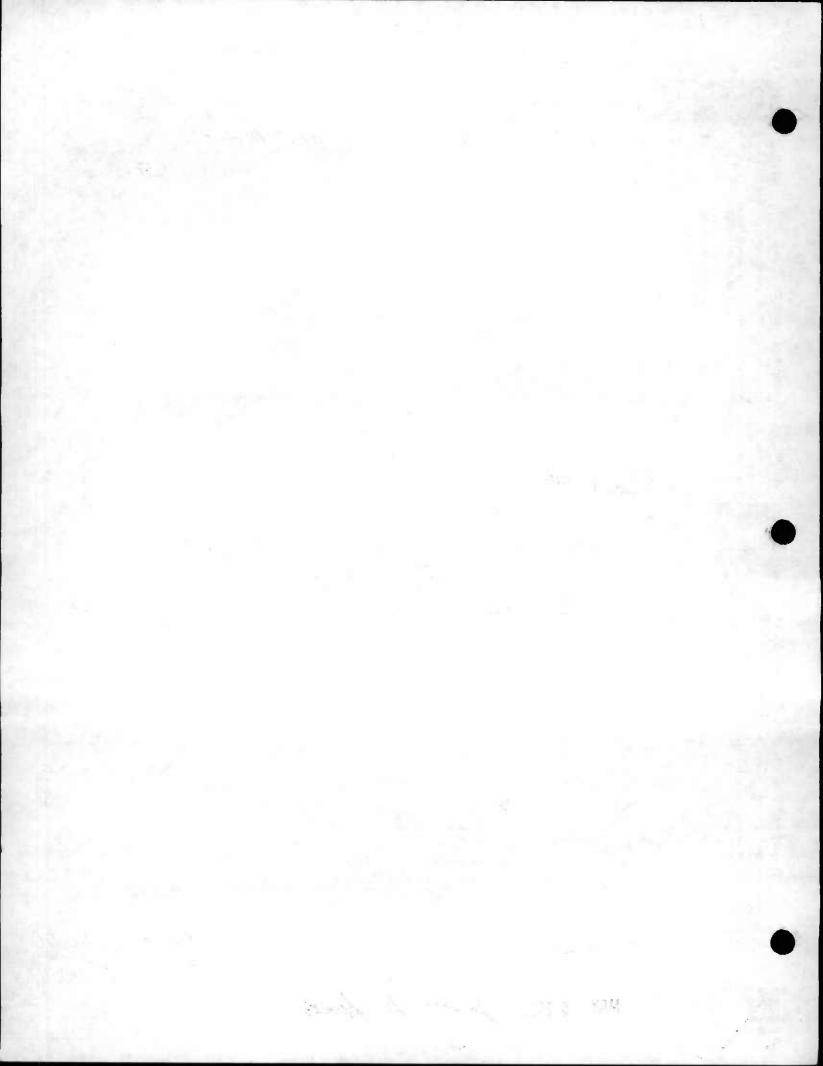
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State of Maryland / Department of Health and Mental Hygiene

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No.		-	no!	1	

	Certificate of Death	Reg. No.						
Physician	1. Decedent's Name (First, Middle, Last)  JOHN LAWRENCE WIGHTON	2. Date of Death Month Dey Yeer  NAY 5 2 000 255 PM						
/Medical Examiner	4a Fecility Neme (If not institution, give street end number)  4b. City, Town  SNA HOSPITAL OF BALTIMORE BALTIMORE	n, or Location of Deeth 4c. County of Death						
Funeral Director	5. Social Security Number  053-30-1727  Usual Residence of Decedent	Hrs. 8. Date of Birth (Month, Dey, Year) (MATCH 29, 37 New York						
e Maryland	10a. Stete 10b. County 10c. City, Town or Location Maryland N/A Baltimore	10d. Inside City Limits 1 ሺ Yes 2 □ No						
Department of Health and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene.  Department of Health and Mentel Hygiene.  Important: If items 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified and injury or other traumatic event, the Medical Examinar must be notified and injury or other traumatic event, the Medical Examinar must be notified.  To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?						
	4405 N. Charles Street  11. Maritel Stetus  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces? Korean 1 ☒ Yes 2 □ No War Yeer or Detes: Era  13. Wes Decedent of Hispenic Origin If Yes, specify Cuben, Mexican, If Yes, specify Cuben, Mexican, If Yes 2 ☒ No Specify:	United States  17 (Specify Yes or No- Puerto Rican, etc.)  14. Race - American Indien, Bleck, White, etc.  Specify: White						
ed within 72 ho ygiene. or than "natura it, me Wedcall Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)							
buld be filed within Mentel Hygiene. Treed other transition of the Mentel Hygiene. To Be Complete.	5+ Public Relations Co	s Name (First, Middle, Maiden Surneme)						
nd 2 should be file lith end Mentel Hy 27 is marked other traumatic event To Be C	3	or Rural Route Number, City or Town, Stete, Zip Code)						
and 2 alith e 27 is	Marcella Gulledge (Friend) 250 East Susquehan	na Avenue Towson, MD 21286						
permit. Pagas 1 and Department of Health Important: If item 27 any Injury or other tr pages.	20a. Method of Disposition  1	Dete 20c. Location - City or Town, State 5/9/00 Baltimore, Maryland						
permit. Pag Department Important: I any Injury o	21. Signature of Funeral Service Licensee  Suru T. Stille  22. Name end Address of Facility Mitchell-Wiedef 6500 York Road	eld Funeral Home, Inc. Baltimore, Maryland 21212						
iras that the death certificate be executed signed by the ettending physicien end doe detached for use as the buriel-transit by Physician/Medical Examiner	Ceuse (Disease or injury thet initiated events resulting in deeth) Lest  Due to (or es a consequence of):  LUNG CANCER	A						
that the death c	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death						
been shoul		24a. Was an eutopsy performed?  24b. Were eutopsy findings eveilable prior to completion of cause of death?						
The lew sate has page 2		1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   1   Yes 2   Ye						
Storiffic octor	25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one)							
Ing Phys After this funerel di	1   Yes 2   Ye	ing Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred						
tal or Attending Programmers after death.  al Director: Attent lied in by the funere Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, State)						
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	place, end due to the ceuse(s) end menner es steted. occurred et the time, date end place, end due to the ceuse(s)						
within to the same of the same	29b. Signature and title of cartifier  29c. License number  212942	29d. Date signed (Month, Dey, Year)  MAY 5, 2000						
CAD	30 Name and address of person who completed cause of deeth (Item 23e) (Type, Print)  TACK E. N. S. M. M. B. B. GREENT,  31. Dete filed (Month, Dey, Year)  MAY 9 2000  Aparts  Aparts	REE RD #200 BAIT, MD, 42						
State Registrar	MAY 9 2000 Denne & Sparks	Δ						



Physician/Medical þ Completed page 2 s Be 0 funeral

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Director: Aft
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To the Hospital or within 24 hours aft To the Funeral DI

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23b. Did tobacco use contributa to the causa of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Pert I. 1 □ Yes 2 □ No 3 □ Probably 4 ☐ Unknown 24b. Were autopsy findings eveilable prior to 24a. Was en eutopsy performed? completion of cause of daeth? Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3X DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2□ No 28e. Dete of Injury (Month, Dey Year) FOUND: 5-1-00 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred A 5 ending FOUND: 1 Naturel M 1 Yes 2 No UNKNOWN 2 Accidant 6 X Could not be 3 Suicide 28f. Location (Street end Number of Rural Route Number, City or Town, State) 700 KENWOOD AVE. 28e. Plece of injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide FOUND AT HOME

29a. Certifian

BALTIMORE, MARYLAND 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data end plece, end dua to tha causa(s) and mannar es stated.

01,2000

(Check only one) Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner steted. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier O.C.M.E MAY

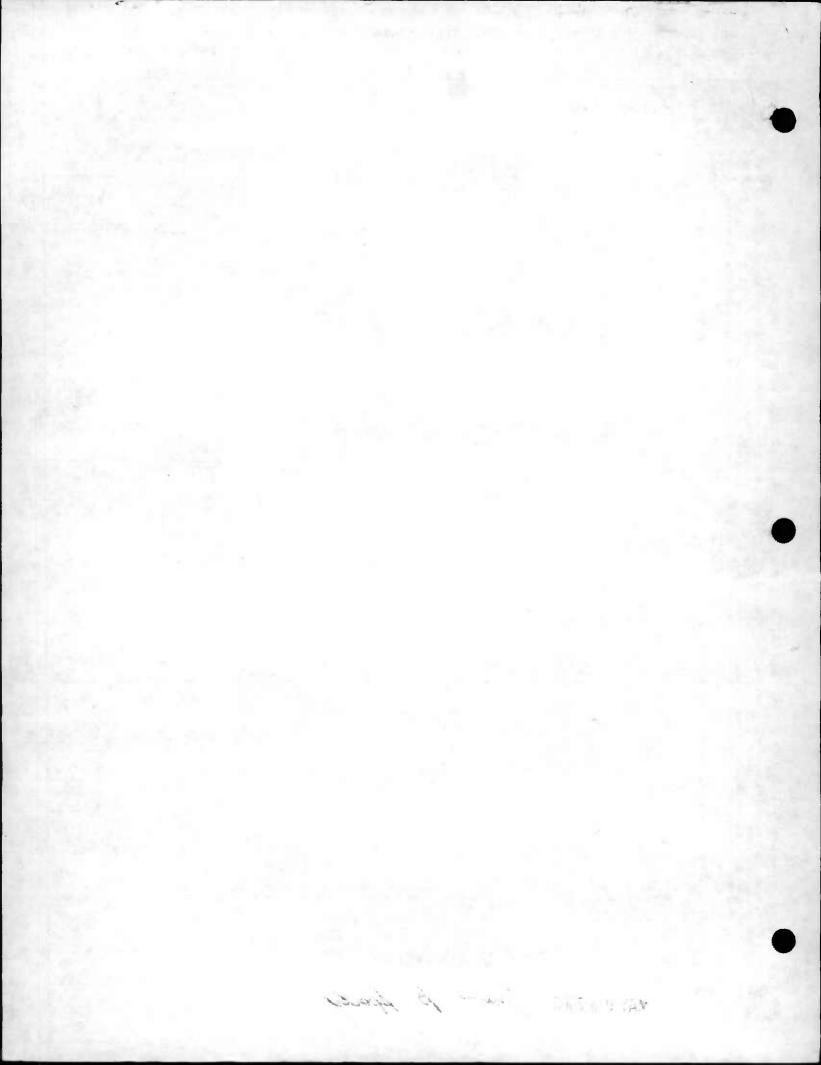
codes 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

SPIRE 31. Data filed (Month, Dey, Year)

MAY 0 9 2000 Mik Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

State Registrar



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

1000	1. Decedent's Nama (First, Middla, Las	ITEMS: #23 PART I, 27 PER MEO G784 Certificate of Death  1. Decedent's Nama (First, Middla, Last)					ath Dey	Year	ima of Death	
ian ical	Clifton Eugene Ward					MAY 0	04 2000   1750			
ner	4a Facility Nama (If not institution, give FRANKLIN SQUARI	E HOSPITAL			ESSEX		BALTIMORE			
	218-44-0956				If Undar 24 Hrs. Hours Min.					
other than "natural", or frame 23e or 28e-f show other than "natural", or frame 23e or 28e-f show vent, the Medical Examiner must be notified at 3e Completed by Funeral Director	Usuel Rasidence of Decedent  10a. Stata 10b. County	10c. C		13000			side City Limits			
	Md. Balti	imore Middle River					per al			
	10e. Street and Number 10f. Zip Coda						10g. Citizan of Wi	hat Country?		
r tems 23a o		9732 Matzon Road			21220		US			
	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas:	If Yas, s	specify Cub	dispanic Origin? (Span, Maxican, Puerto Specify:	pecify Yas or No o Rican, atc.)	Black Specify:	- Amarican Ind t, Whita, etc. White		
-	15. Decedent's Ed (Specify only highest grade) Elemantary/Secondary (0-12)	Education 16a. Decedent's Usual Occupation				16b. Kind of Businass/Industry  Construction				
-		1 yr.	Cons	tion wo						
	17. Fathar's Name (First, Middle, Last)					ama (First, Middle, Maidan Sumama) ela Swalley				
	Clifton W.  19a. Informant's Name/Ralationship (7)		19b. Mailing Addr	ess (Street	and Number or Ru			Stete, Zip Code	)	
	Linda Wilfon				Road B					
	20a. Mathod of Disposition  HD Burial 2 Cramation 3 4 Donation 5 Other (Specify	Hamovai from Stata	Place of Disposition (I cemetery, cremetory (			Dete /9/200		20c. Location · City or Town, Stata  D Baltimore, Md.		
been signed by the ettending physician and been signed by the ettending physician and been signed by Physician/Medical Examiner	Connelly Funeral Home of Esse  300 Mace Avenue Baltimore, Machine Shock, or haart failure. List of one ceuse on each line.  Immediata Ceuse (Final diseasa or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Entar Undartying Cause (Disease or injury that indited avants rasulting in death) Last  Connelly Funeral Home of Esse  300 Mace Avenue Baltimore, Machine Machi							ary lai apprintent onsa	oximata vel Between it and Death	
			asulting in the underlying	no causa cir	van in Part I.	23b. Did	tobacco use con	tribute to the c	ause of death	
	Part II. Other significant conditions or		asulting in the underlyin	ng causa gi	van in Part I.	-		tribute to the c	1.0	
			asulting in tha undarlyin	ng causa gi	van in Part I.	1 🗆 24a. Was part	Yes 2□ No san autopsy ormad?	3 Probably  24b. Were au available complati of death	4 Unknown	
	Part II. Other significant conditions or		asulting in tha undarlyin	ng causa gi		1 🗆 24a. Was part	Yes 2□ No s an autopsy ormad?  Yas 2□ No	3 Probably  24b. Were au availabla complati	4 Unknow topsy findings a prior to on of cause	
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Columbation to be completed by injectable	25. Was casa referred to medical examinar?  1 N Yas 2 No  27. Mennar of Death 1 Natural cuidant invastigation 3 Suicide 4 Homicide  29a. Cartifier 1 Certifying Physics	Hospital: 1 Inpatiant 2  28a. Data of Injury (Month, Day Year)  28e. Plece of Injury - At building, atc. (Spectrum)	□ ER/Outpatient 3⊠ 28b. Tima of Injury M home, farm, straat, facility)	DOA Oti 28c. Inju Wo 1 C	26. Placa of Das nar: 4 □ Nursing H ry at rk? Yas 2 □ No	24a. Was part	Yes 2□ No s an autopsy ormad?  Yas 2□ No ona) Idence 6□Otha how injury occurre  Street and Number win, Stata)  cause(s) and mar	3 Probably  24b. Were au available completi of death  1 Pres  or (Specify)  and  or or Rural Rout	4 Unknow  topsy findings prior to on of cause ?  2□ No	
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Medical Certification: To Be Completed by Physician/Med	Part II. Other significant conditions of the con	Hospital: 1 Inpatiant 2 28a. Data of Injury (Month, Day Year) 28e. Plece of Injury - At building, atc. (Specials To the best of my kinner: On the basis of axaminand manner stated.	DER/Outpatient 3 Nation 28b. Tima of Injury Menor, farm, straat, facility)  Mowledge, death occurrenation and/or invastigat	DOA Ott	26. Placa of Das nar: 4 ☐ Nursing H ry at rk?   Yas 2 ☐ No ma, data and place	24a. Was part	Yes 2□ No s an autopsy ormad?  Yas 2□ No ona) dence 6□Otha how injury occurre  (Street and Number win, Stata)  cause(s) and mar data and place, a	3 Probably  24b. Were au available completi of death'  1 Pes  or (Specify)  and ar or Rural Route and dua to tha completion of the complet	topsy findings prior to on of cause?  2 No  ta Number,  ausa(s)	

DHMH 16 Rev 6/95

MAY 9 3 2000 Survey Survey Survey

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 210 Dey Month Year **Physician** FLLA WELLS 2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner BALTIMORE Hospice Joseph Kicher TI no If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral** Days Hours Months 10 M 20 F 21720 5915 Director 10-21-1924 MARY land Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No tem 27 is marked other than "natural", or items 23a or 28a-f si other traumatic event, the Medical Examinar must be notified Director MARYland none 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 815 ARAtoga 21201 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Maritel Status Black, White, etc. Never Married 2 ☐ Married 1 Yes 2 No Specify: SPECITY: AMERICAN 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Keceptemist School 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be ould be f WEILS NELSOL 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Pennhurst Ave 21215-4836 Bacto, md Item 27 i ANICE Taylor Baltimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 7 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete mportant: If Rbutus Memorcal 4 ☐ Donetion 5 ☐ Other (Specify) ARU/and 22. Name and Address of Facility Lancy Abutes. 21. Signature of Funeral Service Licensee FUNEKAC W. FRANKlin BAHIMORE Md 2/229 au 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear, ailure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical ENDOMETRIAL CANCER STAGE IV MONTHS Examiner Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): that initiated events resulting in death) Lest Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by the 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No ģ Division of Vital Records, 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy Completed 2 D No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 100 28c. Injury et Work? 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Certification: Atter 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide To the Hospital o within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and menner stated. 29e. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of gertifier 29c. License number 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 300 ARMURY PLACE SUITE 34 BACTIMORE MD 21201 MACGIBBON 40 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State Registrar

BANKET INC.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Amended Item#5 perINFG787 9/12/2000 EW 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Dey Th **Physician** Month Yaar WAGNER KATHRYN 6.45P MAY 2000 05 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE | Hunder 1 Yaar | Hunder 24 Hrs. | 8. Dete of Birth (Month, Pay, Aug. 1.78) Jonhital Confer. North weal-218-10-9810 6 Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foraign **Funeral** Year) 18 1□ M 20 F 212-10 6280 Yrs. Indiana Aug. Director Usual Rasidance of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at MD Baltimore Director Catonsville 1 ☐ Yes ⊅ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1512 Copeland Road 21228 USA Funeral 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yas, Giva Yaar or Detas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after Hygiane. ther than "natural", or ite 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 18a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Secretary Legal permit. Peges 1 end 2 should be file Depertment of Health end Mentel Hy Important: If them 27 is merked othe any injury or other traumstic event. 17. Fether's Nema (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surneme) (Unavailable) McCormick (Unavailable) 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Marlene Mejia/Daughter 1512 Copeland Road, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Burlal 2 Cremation 3 Ramoval from Stete Loudon Park Cemetery 5/8/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Neme end Address of Facility 21. Signeture of Funeral Service Licenses Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 semmer 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting in deeth) /Medical a CHRONIC OBSTRUCTIVE PULMONARY DISEASE Examiner Dua to (or as a consequance of) Examiner physician and s the burial-transit certificete be axecuted Sequantially list conditions, if any, leeding to immediate causa. Entar Underlying Cause (Disease or Injury Dua to (or as a consequence of): 68760 Physician/Medical that initiated avants resulting in daath) Last Dua to (or as a consequence of): 98 attending I Box P.O. 1 ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown signed b CONGESTIVE HEART PAILURE Records, by 24b. Wara autopsy findings evelleble prior to completion of ceusa of daath? Completed 24a. Wes en eutopsy performed? peen ATHEROSCLEROTIC CARDIOVASZULAR DISEASE cate has 2 No 1 ☐ Yas 20 No certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completaly filled in by the funeral director, to 25. Was cesa rafarred to medical Be 28. Placa of Death (Check only ona) 1 Yas 2 No 1 Inpatient Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 2 ☐ Accident 1 Tas 2 No invastigation 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide cal 29a, Cartifier 1 Certifying Phyaician: To tha best of my knowledga, death occurred at tha time, data and place, and dua to tha cause(s) end menner es steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, dete and place, and dua to tha causa(s) end mannar stated. (Check only one) Med 29b. Signatura and titla at out ther 29d. Data signed (Month, Day, Year) MAY 05Th 42723 2000 30. Nama and addrass of person who complated ceuse of death (Itam 23a) (Type, Print) MORTHWEST HOSPITAL CENTER

State Registrar

**DHMH 16 Rev 6/95** 

2000

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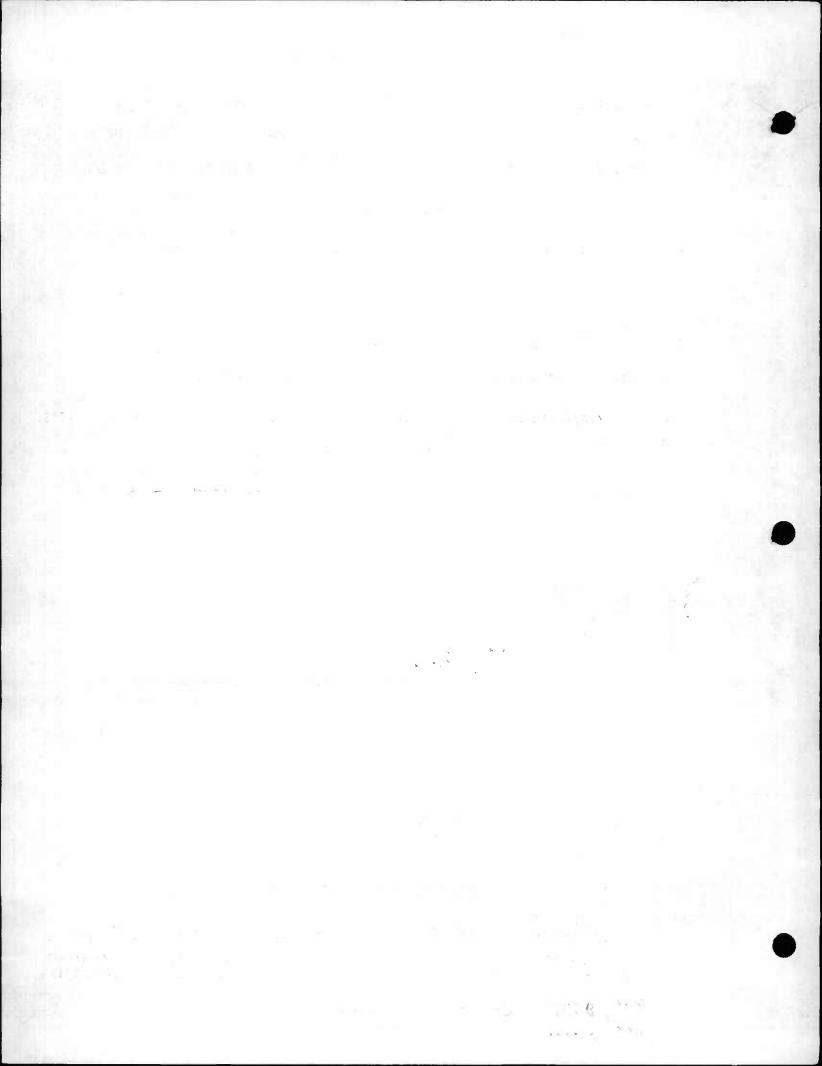
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HARISH 32. Registrar's Signature

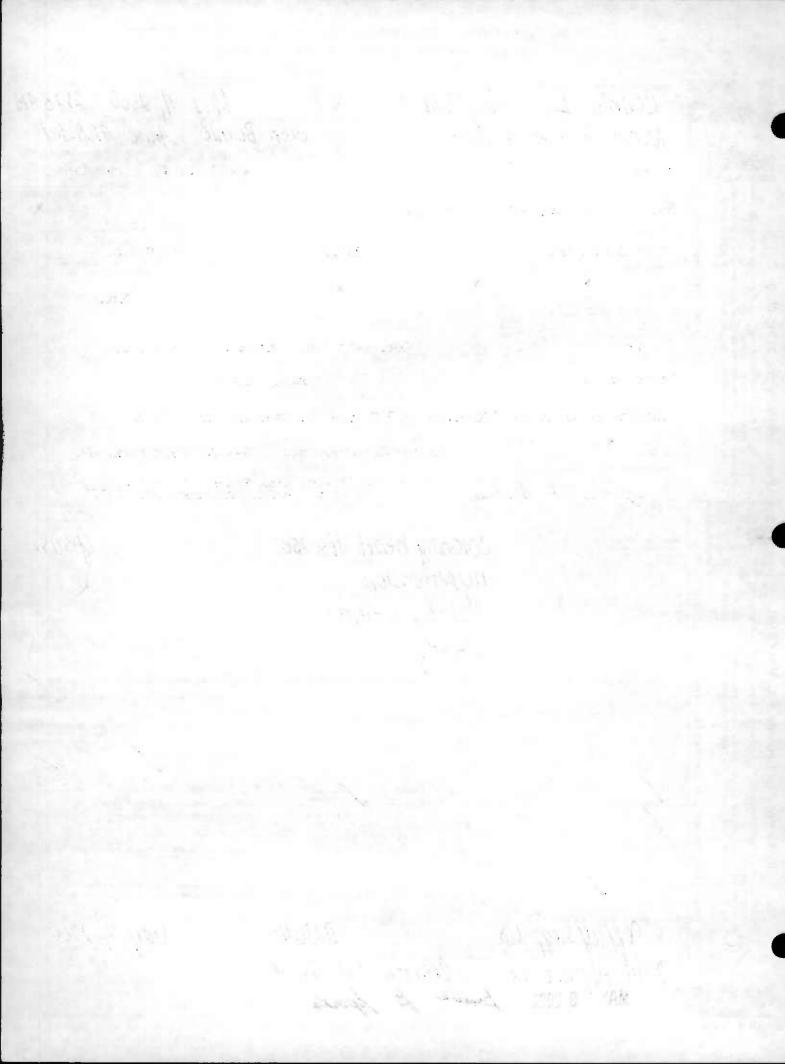
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RAMPALLITOWN



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 **Physician** /Medical 4c County of Death 4a Facility Name (If not inglitution, give street and number NOTH) AVUNGE HOSD 4b. City, Town, or Location of **Examiner** Glen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1□ M 2KF Yrs. Director 220-66-5635 44 April 18, 1956 Maryland Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene. Inprocess: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be retiture. Once 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. 1 ☐ Yes 2 No Anne Arundel Pasadena Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1655 Colony Rd. 21122 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Corporate Contributions Adm. B.G.E. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Howard Watts Betty Kreiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Wingfield (Husband) 1655 Colong Rd. Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Greenmount Crematory 5-9-00 Baltimore, MD. 21. Signature of Funeral Service Licansee 22. Name end Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physician end for use es the buriel-trensit The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last P.O. Box 68760, signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? been signated Completed 24a. Was an autopsy performed this certificate has rel director, page 2 1 Tyes 20 No 1 ☐ Yes 2 LINO Hospital or Attending Physician: 24 hours efter deeth. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28c. Injury at Work? 27. Manger of Deeth 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide in 24 hour. the Funeral Directory 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. within 24 hou To the Funel completely fil edicai 29a, Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ause of deeth (Item 23e) (Type, Print) 31. Dete filed / 32. Registrar's Signature g") State Registrar

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**DHMH 16 Rev 6/95** 

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32. Registrar's Signatura

30. Nama and address of person who completed cause of death (flem 23a) (Type, Print)

2000

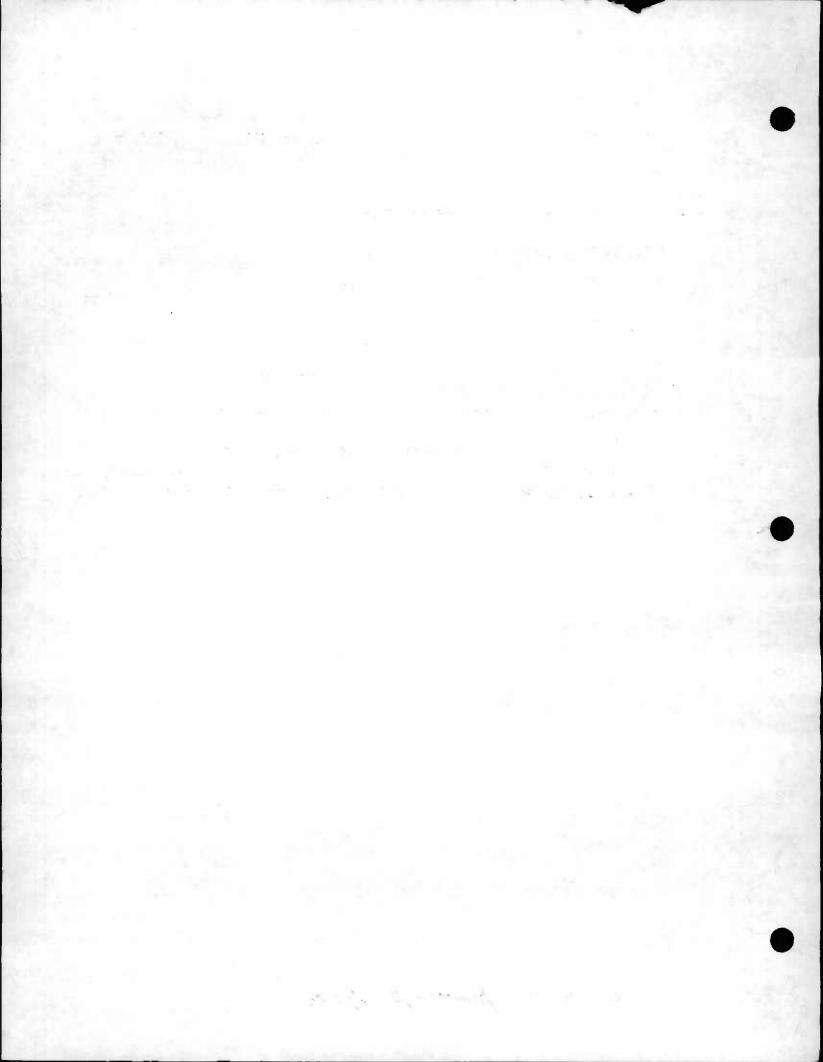
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Dey **Physician** 00 George Andy Xenakis IOAV May 4, 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner St. Joseph Medical Center Towson Baltimore Co. # Under 1 Yeer | # Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | March 10, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** N M 2□ F West 76 Yes Director 235-28-6500 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martal Hyglene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other treumatic event, the Maddies Experiments 200 or 28a-f show boxe. 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 Wo Director MD Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7325 Yorktowne Drive 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 (X/Yes 2 □ No If Yes, Give Yeer or Detes: WW I 14. Race - American Indien, Bleck, Whita, atc. 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Nevar Married 2 Merried 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5+ U.S.Government Engineer 17. Father's Name (First, Middle, Last) Athanasios Zorzi Xenakis 18. Mothar's Name (First, Middle, Maiden Sumeme) B Canela Kotis 19e. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 7325 Yorktowne Drive Towson, MD 21204 Helen K. Xenakis - Wife 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stete Dulaney Valley Mem.Grds.5/8/00 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility.
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 23a. Part1. Enter the diseasa, or complications that clusted the shock, or heert failura. List only one cause on aach in a Do not enter the mode of dying, such as cardiac or raspiratory errest, Approximete Intervel Between Onset end Death **Physician** Immediete Causa (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner Atherosclavy ettending physicien and for use es the burial-transit certificate be executed Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Dua to (or es e consequence of): Box 68760. Due to (or es a consequence of): The law requires that the deeth P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. ģ 24b. Wera eutopsy tindings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Wes casa referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Vaturel 5 Panding 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Tall Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2000 5 D30801 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Benjamin K. Yorkoff 6701 N. Charles St. Baltimore, MD 21204 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAY Registrar 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 10e per fh G783 5/9/00 vg 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month 01:57 Kyuns 8 Y00 2000 /Medical 4a Facility Name (If Acrinstitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore mercy Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey. Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 413.69.1129 Deys Hours 1 □ M 200F Months 2.7 Yrs. Director 0707 ORRA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item  $z_T$  is marked other than "natural", or items  $z_{3a}$  or  $z_{8a-f}$  show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director mp Timonium 10e. Street and Number 2307 Wonderview Road 10f. Zip Code 10g. Citizen of Whet Country? 21093 Wonder VIEW death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinat 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Korean 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Éducation (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student 12 L 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HO. llun9 oung-Hee VOC 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) heistepher 20b. Place of Disposition (Name of cametery, crematory or other place) 11MONIUM Md 21 **DROHOR** 20a. Method of Disposition May 10 1 Surial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 2000 22. Name and Address of Facility E'Vans Funefal Chapel 21. Signature of Etineral Service Licen K.Rd. 21093 TIMONIUM 29a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final 3 months . Metastatic adenocarcinoma disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner 2 months bowel ob struction physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of): certificate be exec Box 68760. physician Physician/Medical Due to (or as a consequence of) ettanding p signed by the et d be detached for Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed hes 1 Yes 2 No 2 PNO Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200No P 1 ☐ Yes 1 Depatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Naturel death. 1 TYes 2 □ No 2 Accident or Attendation of a star death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Mospital of 24 hours a Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) AU4176435 05/08/2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 5360 oldstone Ct. Columbia MD 21045 Holly Hales MO

32. Registrar's Signature

DHMH 16 Rev 6/95

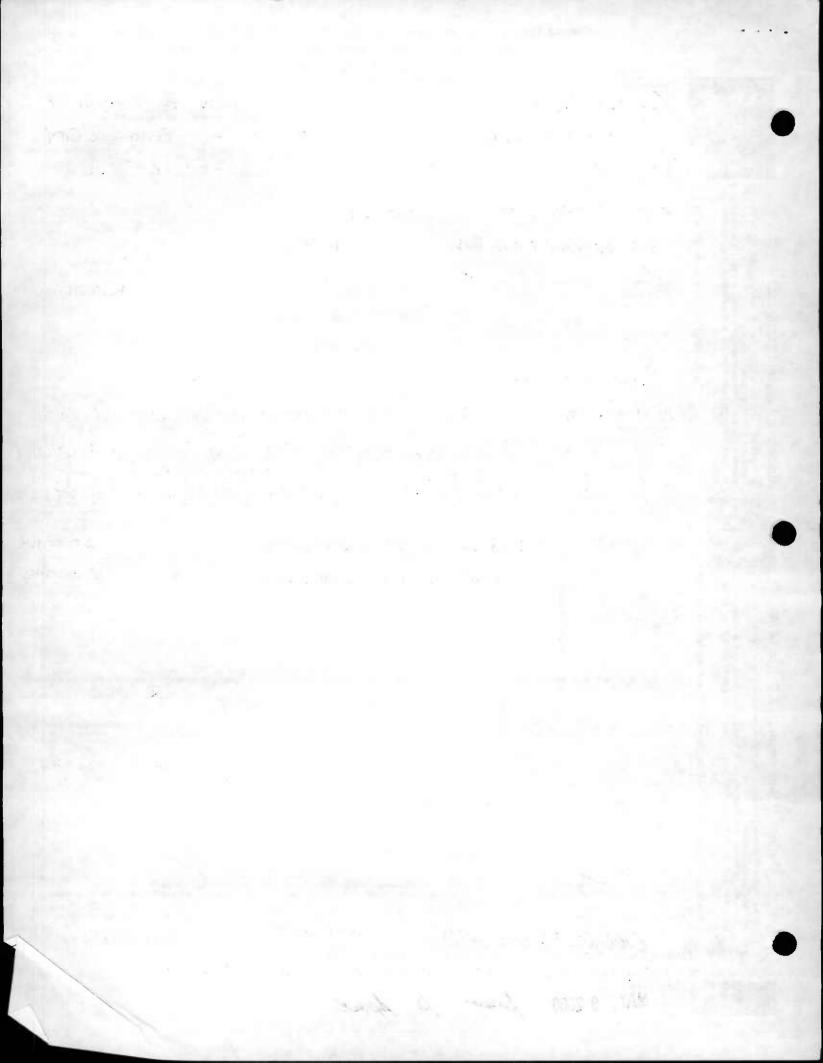
State

Registrar

31. Date filed (Month, Day, Year)

9 2000

MAY



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4921. Certificate of Death AMEND#26 PER MD. G783 5-9-2000 JAB 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year **Physician** MAY 6, 2000 IRENE YAKER 8:10 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner NORTH OAKS HEALTH CENTER BALTIMORE PIKESVILLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2 TF 214-12-2065 Director AUG. 8, 1908 RUSSIA Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show 1 ☐ Yes 2 1 No Director BALTIMORE PIKESVILLE 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 725 MT. WILSON LANE #135 21208 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is methed other than "natural", or its any fnjury or other traumatic event, the Medical Examinas 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: À 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be **ABRAHAM ENOFSKY** 2 RACHEL FISH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MILDRED ADLER / NIECE 111 HAMLET HILL ROAD #1004 - BALTIMORE, MD 21210 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 5/8/00 RANDALLSTOWN, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. we 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Preumonia /Medical Immediate Ceuse (Finel week diseese or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner physician end the burief-transit The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or es e consequenca of): 9SH Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Œ No 3 Probably 4 Unknown Oskoporosis signed t þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 KNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Recidence 6 NOther (Specify) CFN FR Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 ENaturel 5 ☐ Pending n 24 hours after death.

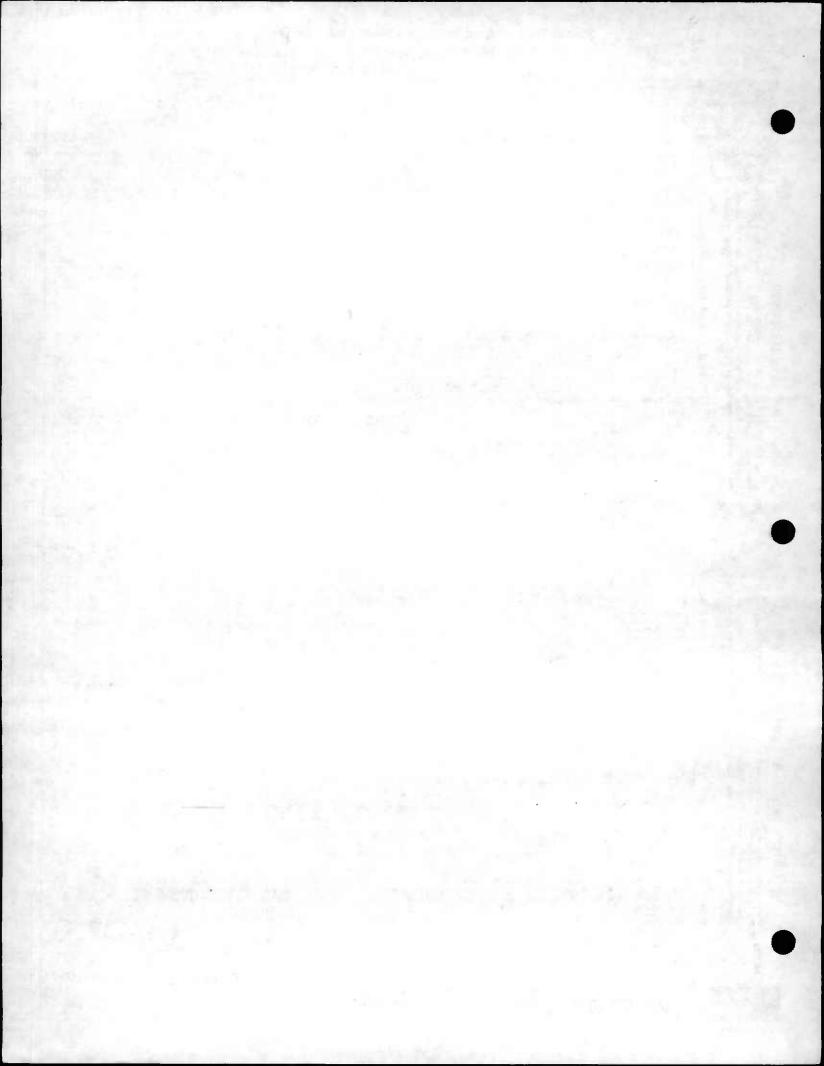
Funeral Director: Aft pletely filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not ba determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospitat o within 24 hours af To the Funeral Di Completely filled is Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es steled.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and menner steled. edical 29s. Certifie 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 038675 8 2000 MD 30. Name and ss of person who completed cause of death (Item 23a) (Type, Print) MESHULAM JUEZ PAUL PL MD 301 ST 5-15E 605 BALTIMORE MOZIZOZ

**DHMH 16 Rev 6/95** 

State Registrar 0 9 2000 Day, Year)

32. Registrer's Sign



Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** Month . GARY ZINCK, WILLIAM JR 123084 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner JOHNS HOPIGINS BAYVIEW MEDICAL CENTER BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1ØM 2□F 220 08 0863 Yrs Director January 29 1983 maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f sho must be notified at BALTIMORE 1 ☐ Yes 2☐ No MD Baltimore Director 28a-f 10e. Street and Number PAULETTE 10f. Zip Code 10g. Citizen of Whet Country? 21222 UnitED STATES 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indien, Black, White, etc. 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Never Married 2 Merried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 natural, or Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) None permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marriaed othe any Injury or other traumatic event access. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be William Sr. Zinck, ADBASS WARTHEN G. JACQUELINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Apt. #101, Beltimore, MD Rolette Rd. Abba SS (Stepfather) 2002 Khalid 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Glen Burnie, MD Glen Haven Cemetery 5-8-00 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Fecility 1328 Sulphur Spring Rd. Arbutus, MD. 21237 cy Ambrose Funeral Home, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pulmonary 2 hours Examiner Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury P.O. Box 68760, unters that initieted events resulting in death) Last Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No Restrictive 3 Probably 4 Unknown signed b Records, 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? 20 No 1 ☐ Yes → No 1 Yes certificate Division of Vitai al or Attending Physician: The safer death.
In Director: After this certificate of in by the funeral director, pa Be 25. Wes case referred to medical examiner? 26. Pleca of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2000

32. Registrer's Signature

ROBERT DUDAS

31. Date filed (Month, Day, Year)

MAY

10050109

JOHNS HOWHUS BAYVIEW MEDICAL CONTER 4940 EASTERN AVE BALTIMORE NO 4124

2,000

### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Tima of Death 2. Date of Death Month Dav Yaar 0425 AM **Physician** ZELTMAN GEORGE MAY 08 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL COLUMBIA HOWAR COUNTY CENERAL If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** 1 M 2 □ F 83 Director Feb. 2, 1916 212-30-8797 Maryland Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryland nent of Heelth and Mertel Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified at 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Funeral Director MD Howard Elkridge 10e. Street and Number 10f Zip Coda 10g Citizen of What Country? 6200 Marshalee Drive 21075 U.S.A. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedant Ever in U,S. Armed Forcas? Race - Amarican Indien, Black, Whita, atc. 11. Merital Status 1 XYas 2 No If Yas, Giva Yaar or Datas: Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2√No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 6 Farmer Farming 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Father's Nama (First, Middla, Last) Jacob Ze1tman Katherine Kraft 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Heeith e Important: if Item 27 is any injury or other tra Ralph Stup Brother-in-Law 6304 Marshalee Drive Elkridge, Maryland 21075 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition etery, crematory or othar place) 1 Burial 2 □ Crametion 3 □ Ramoval from State St. Johns Cemetery 5-11-00Ellicott City, Maryland 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funeral Sarvice Licensaa 22. Nama and Addrass of Fecility Gary L. Kaufman F.H. Meadowridge Memorial Park Lemmer 7250 Washington Boulevard Elkridge, Maryland21075 23a. Pert1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on each line. **Physician** ACUTE CEREBROVASCULAR /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner ONGESTIVE MUNTH. The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaasa or Injury that infilated avents resulting in daeth) Last Dua to (or as a consequance of) and Box 68760, physicien Completed by Physician/Medical the Due to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not rasulting in the undarlying ceusa given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown of Vitai Records, 24a. Wes an autopsy performed? 24b. Wara autopsy findings availabla prior to complation of ceusa of daath? certificata hes 1 Tas 2 12 No 1 ☐ Yas 2 ☐ No after deeth.

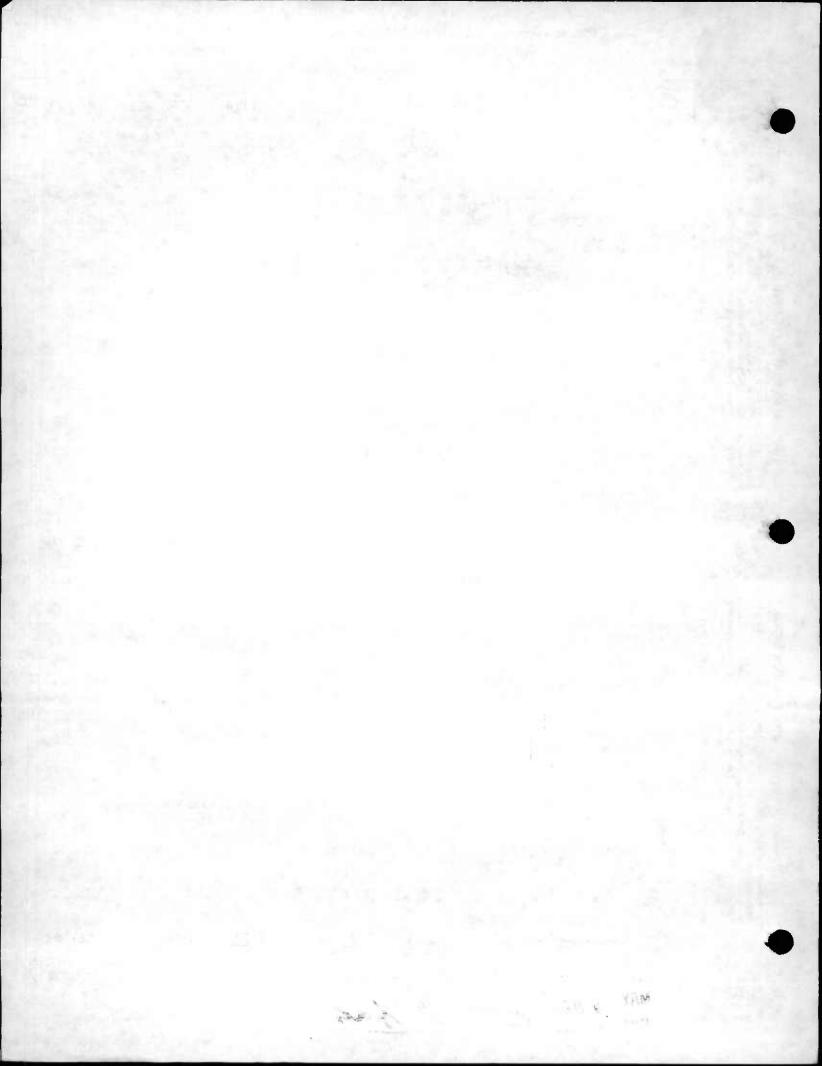
Director: After this certification of the funeral director. Physician: Be 25. Was cesa referred to medical 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Medical Certification: To 1 DInpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural Division or Attending 5 Panding investigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicida To the Hospital o within 24 hours at To the Funeral DI 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to tha ceuse(s) end menner es steted.

2 Medical Examiner: On the best of axamination end/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifian completely 29b. Signeture end title of certifier 29c. License number 29d. Data signad (Month, Dey, Year) Mi. 08 30. Nama and addrass of person who complated cause of deeth (Item 23a) (Type, Print)

RASAR ABU M.D. 6201 GR COLLEGE PARK 6201 GREENBELT (D) # M-14 Dey, Year) 9 201 32. Registrer's Signatura State Registrar

**ORIGINAL** 

**DHMH 16 Rsv 6/95** 



### Please Ty

10f. Zlp Code

Rockville

10c. City. Town or Location

Ple		Print in Black In					•		_		
	State of	of Maryland / Depa	artment o rtificate			nd M		ene g. No.	00	149	27
Decedent's Name (First, Mich.	O COLUMN TO THE REAL PROPERTY.	erine Irene Ad	cuff				2. Dete of Deeth April		2000		P.M.
4a. Fecility Neme (If not institute  Montgomery Ho		,		4	lb. City, Town		ocation of Deeth		ounty of Dealt		
5. Social Security Number 409–78–4028	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. last birthday) 51 Yrs.		ear ays	If Under 24 Hours	Hrs. Min.	8. Dete of Birth (Month, Dey, May 5,	Year) L948	9. Birth Cor Arl	Birthplece (State or Foreig Country) Arkansas	

20852

10d. Inside City Limits

1 ☐ Yes 2 TN No

10g. Citizen of Whet Country?

USA

Physician /Medical Examiner

10b. County

1429 Templeton Place

Montgomery

10a. State

Director

MD

10e. Street end Number

Usual Residence of Decedent

**Funeral** Director

the Maryland "natural", or items 23s or 28s-f show daath pamit. Pages 1 and 2 should be filed within 72 hours aftar c Dapartment of Health and Mantai Hygiene. Important: If item 27 is merked other than "naturat," or item any injury or other traumatic event, tra Mexical Evantura

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

The law requires that the death cartificate be axecuted the burial-transi and physician for usa as detached is cartificata has been signed by director, page 2 should be detac "hysician: this runarai ē or Attanding To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / the in by t filled complately

Records, P.O. Box 68760.

of Vital

Division

Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Psychology U. S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton L. Acuff Pearle C. Cornwell 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1179 Barnes Road Ann C. Acuff - Sister Anticoch, TN 37013 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Algood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 4/25/00 Algood, TN 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Joseph Gawler's Sons 20016 5130 WI Ave. N.W. Washington, D. C. otombater 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final diseese or condition resulting in death) Subarachnoid Hemorrage 1 Month Due to (or es e consequence of) Examir Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eulopsy findings evalleble prior to completion of cause of deeth? Completed 24a. Wes en eulopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other:  $_{4\square \ \text{Nursing Home}}$  5  $\square$  Residence 6  $\boxtimes$ Other (Specify) Hospice Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Cx Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of partifier 29c. License number 29d. Date signed (Month, Dey, Year) D 37620 22, April 2000

**DHMH 16 Bey 6/95** 

State

Registrar

30. Name

Mark Godec, M. D.

31. Dale filed (Month, Day, Year)

and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

2000

32. Registrar's Signeture

6001 Muncaster Mill Road

Rockville,

20855

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Data of Death Month Day Yaar **Physician** RODRICOUE D. ADAMS, SR. 17, 2000 APRIL 0924 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Jan. 23, 1952 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** M 2□ F Months Yrs. Director 48 Maryland 218-54-7366 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4 23a 4720 Wightman Road 20879 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11 Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is merited other than "naturel", or her any injury or other traumatic event, the Medical Examines 200s. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yas 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) R.S. Willard Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Packaging Co. 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Adams Wilma Frazier 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Reletionship (Type, Print) Kendra L. Adams (Daughter) 19661 Crystal Rock Dr., Germantown, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Brooke Grove Cem. 4/24/00 Laytonsville, MD 21. Signature of Funeral Service (3) 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximata Intervel Between Onset end Deeth Physician Immediate Cause (Final diseasa or condition rasulting in death) /Medical envorion M Examiner Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): ending physician ruse as the burial Box 68760. Dua to (or as a consequence of) P.O. P Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown is certificate has been signed I director, page 2 should be det Records, þ 24b. Wara autopsy findings eveilabla prior to completion of causa of death? Be Completed 24a. Was an eutopsy 1 ☐ Yas 2 No certificate 1 Yes 2 No Division of Vital or Attending Physicien: 25. Was casa referred to medicat 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2KNo Certification: To Impatient 2 ER/Outpatient 3 DOA this funerei 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred After 5 Pending investigation Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

2

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and titla of certifier

Mendhiratta 31. Data filed (Month, Day, Year) APR 25 2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

2401 32. Registrer's Signeture

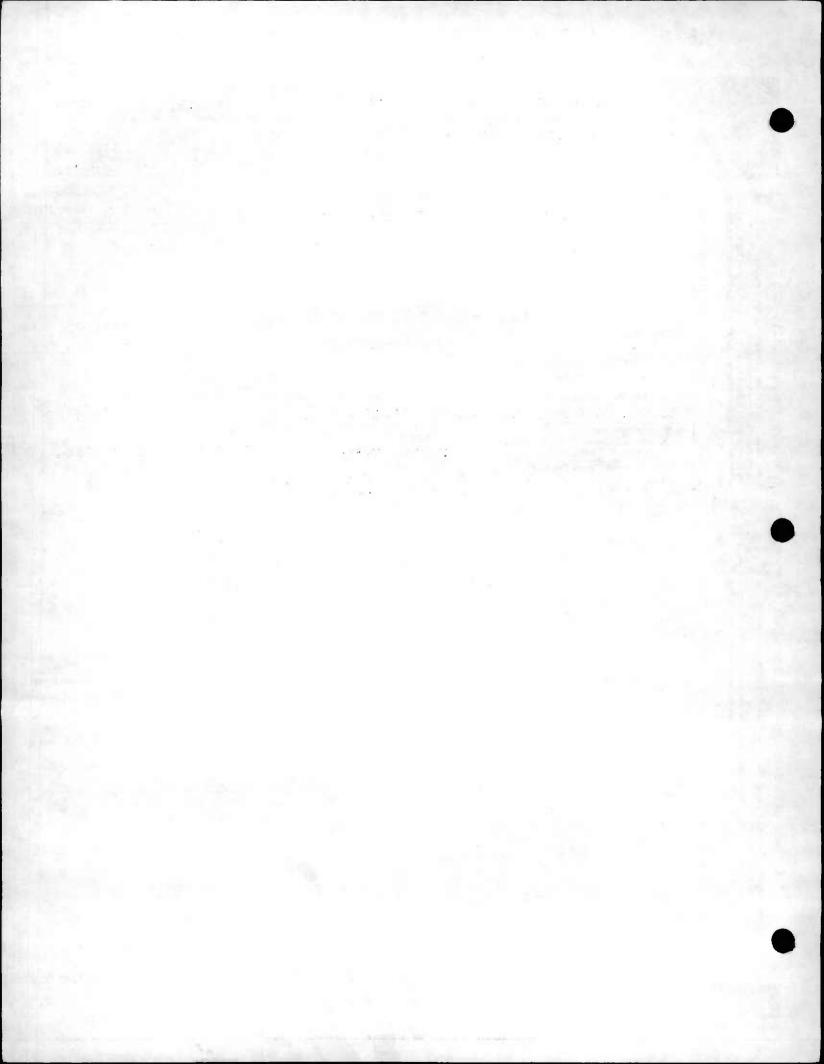
Research BLVD Suite 340 Rockville MD 20854

Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse number

29d. Data signed (Month, Day, Year)



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth April 17, 2000 Mary Elizabeth Abel 5:30 AM 4e Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Church Hill 726 Southeast Creek Road (Residence) Oueen Anne's If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth 9. Birthplece (State or F (Month, Dey Year) October 17, 1929 Wilmington, DE 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 1□M 2XF Months Deys Hours 70 221-20-8395 Usuai Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Queen Anne's Church Hill 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 726 Southeast Creek Road 21623 USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Genealogist Genealogy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) David Appleby Estelle Sweatman 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Russell Newlin Abel/Husband 726 Southeast Creek Road, Church Hill, MD 21623 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Locetion - City or Town, Stete Date 1 Buriel 2 Cremetion 3 Removel from Stete Church Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Unk. Church Hill, MD 21. Signature of Funeral Se 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 408 S.Liberty Street, Centreville, MD 21617 caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, neach line. 23a. Pert1. Enter the disease, or complications to shock, or heart feilure. List only one cause Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) e. END OMETRIAL CANCER WITH PULMONARY Due to (or es e consequence of): METASTASES Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 X No 1 ☐ Yes 2 No 26. Piece of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

10a. State

Directo

Funeral

þ

Completed

Be

2

**Euneral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, or Medical Examinations in the notified at energy.

altimore, Maryland 21215-0020

/Medical

Examiner physician and the burial-transit attanding pl signed by the at d be detached for should his certificate has b

The law requires that the deeth certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be 2 After this funeral Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth

1 Naturel 3 Suicide 4 Homicide

29a. Certifier

(Check only one)

5 ☐ Pending investigation

28a. Date of Injury (Month, Dey Year) 6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. fnjury et Work? 1 Yes 2 No

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Certifying Phyelclen: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and menner steted.

28d. Describe how injury occurred

29b. Signeture end title of cartifier

0041587

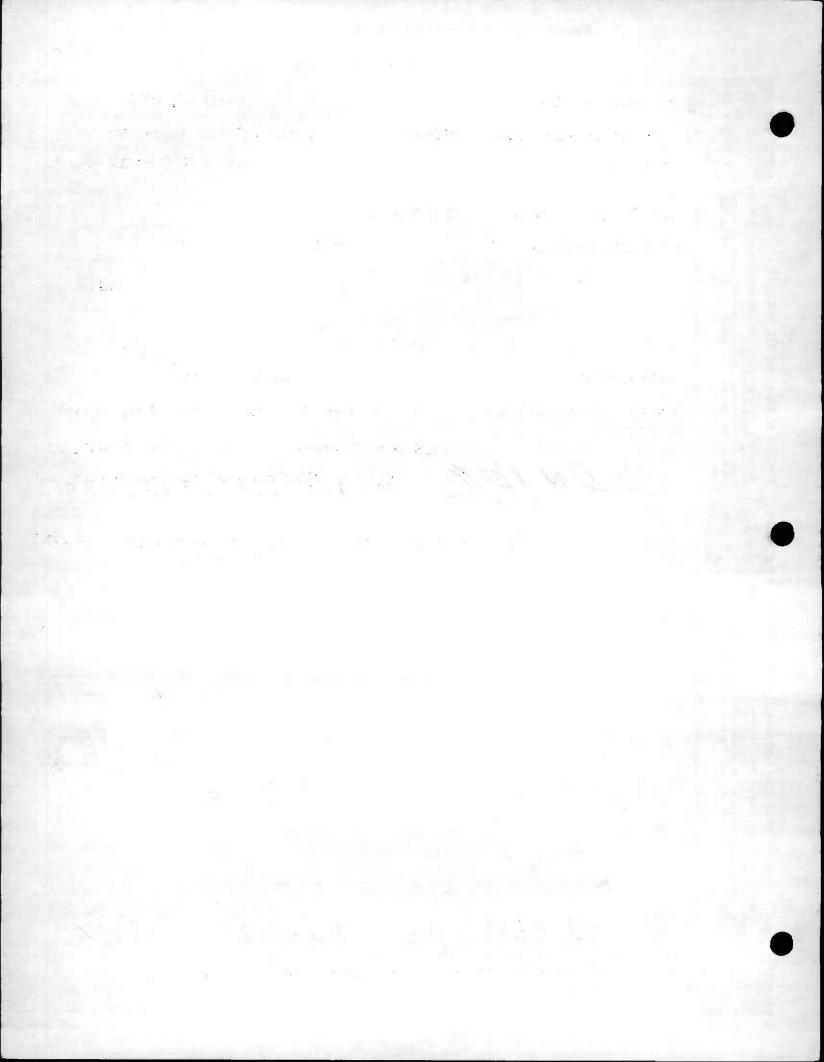
29d. Date signed (Month, Dey, Year) 00

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620 10 32. Registrar's Signature

State Registrar

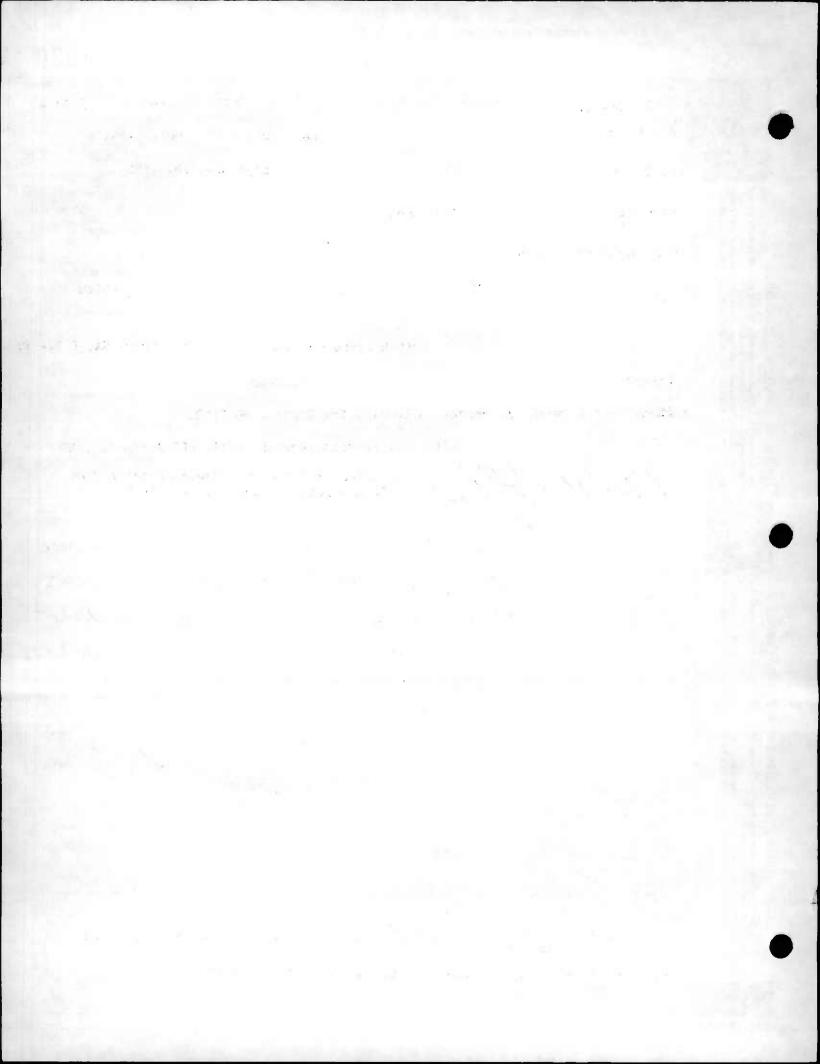
edicai



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 April 17, Physician Mary Ammer 5:47 AM Barbara /Medical 4a Facility Name (If not Institution, give street end number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Corsica Hills Queen Anne's Centreville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 □ M 28 □ F September 28, 1905 Hungary Yrs Director 168-05-1565 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "netural", or Items 23s or 28a-f show traumatic event, the Madical Examiner must be notified at 1X Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 21230 2608 Marbourne Avenue Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - Amarican Indian Black, Whita, atc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ZOXNo Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify. Specify: White þ 3√Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 bepartment of Health and Mantal Hygiene. Important: If from 27 is marked other than "he any Injury or other traumatic even. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric 10 Switch Board Operator 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) Anthony Amelia Eufemia/Daughter 3 Downing St. Easton, MD 21601 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Hillcrest MemorialCemetery 4/19/2000 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 21. Signatur@of Euneral Service Licenses 106 Shamrock Rd. Chester, MD 21619 used tha death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one charge on e **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Rune the attending physician and ned for use as the burial-tran-Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due o (or es a consequence of): death certificate be axec Division of Vital Records, P.O. Box 68760, MOUSIN Physician/Medicai Due to (or as a consaquence of) been signed by the should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 ☐ Probabiy 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s cartificate has 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No after death.

Director: After this cartified 25. Was cese referred temedical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Waturel 28a. Date of injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medicai completaly (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certi 29c. Licensa number 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Dr. Kathleen Hoey 2540 Centreville Rd. Centreville, MD 21617 31. Date filad (Month APR aT) 32. Registrar's Signature State souls Registrar



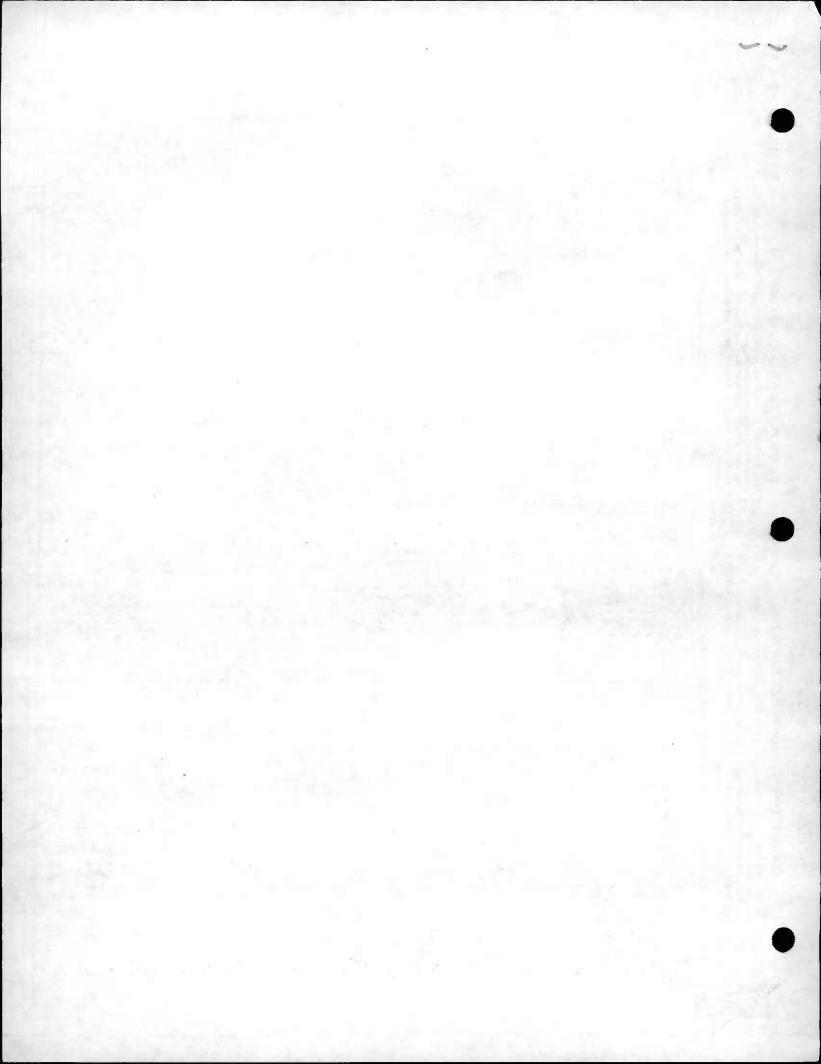
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 4/24/2000, JW, Mont. Co 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician 4b. City, Town, or Location of Death Elliott Brannock 30am UC33 /Medical 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Suburban Hospital

5. Social Security Number 6. Sex, Montgomery a Rintholad If Under 1 Year 6. Sex, 1D M 2□ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Year) 220 17-453 21 Yrs. Director 1978 W.S. Maryland June 10. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow be notified at 1 Yes 2 No Director Prthesodo lantaomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20816 238 5103 Brookylew Drive 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No No If Yes, Give Yeer or Dates: natural, or flems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify 9 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Student College other parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lujury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Duke Brannock Lynn Mechling 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Brookylew Drive Bethesda, MD 20816 unn Mechling/Mother 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Anatomic bift Foundation 4/21/00 Laurel, MU 22. Name and Address of Facility
Anatomic Gift Foundation
13948 Baltimore Avenue Laurel, MD 20707 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear tellura. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** immediate Ceuse (Finel disease or condition resulting in death) /Medical Junsho Wouna Examiner Due to (or es e consequence of): Physician/Medical Examiner e nression Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-tren Due to (or es e consequence of): Due to (or es a consequença of) resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 NO 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 3RANNOCK, 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Compatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred injury 5 Pending investigation SeH 1 Naturel frint 110 April 18,2000 1 Yes ea guns ho death. 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Bural Houte Number, 5163) From State) Gu Drive Bethesda, MD 20816 Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital or ă home To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lomsko, 10 30. Name end address of person who completed cause of deeth (Item 23a) (Type, P,rint) Ke, PMB 348, Rockville, MD 20852 atricia 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar 2000

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #17,4/27/2000, BMW, Montg. Co. Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Dey 2000 April 23, Physician Everett LeRoy Barton 7:15 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 13813 Berryville Road Germantown Montgomery 8. Date of Birth (Month, Day, Year) Ian 25, 1 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Yrs. 61 1939 215-36-3255 Director Maryland **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Maryla al hygient construer, or flarms 23e or 28e-f ahon other than "natural", or flarms 23e or 28e-f ahon vent, its Medical Examiner mast be notified at 1 ☐ Yes 2 No Director Montgomery Maryland Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13813 Berryville Road 20874 Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber | permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important; if them 27 is married other th any injury or other traumatic event, that alose. 10 Plumbing 17. Father's Name (First, Middle, Last)
Charles W. Barton
Joseph Charles Barton 18. Mother's Name (First, Middle, Maiden Surname) Gladys Hamman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Barton/Wife 13813 Berryville Rd. Germantown, MD 20874 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Derwood, Maryland Ricketts Family Cemetery 4/26/00 21. Signature of Funeral Service Licenses 22. Name and Address of Feoility DeVol Funeral Home  $2222\ Wisconsin$  Ave. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardio Respiratory Failure Examiner Due to (or as e consequence of): Examiner Terminal Larynx Cancer nding physician and use as the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of) sate has been signed by the pega 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1⊠ Yes 2□ No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificate Division of Vital tall or Attending Physicien: The after death.

I Director: After this cartificated in by the funeral director, pe 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 \$\omega\$ Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number. City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completaly filled in 29a. Certifier HY Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

16

State Registrar

31. Date filed (Month, Day, Year) APR 2 7 2000

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29b. Signature and title of certifier

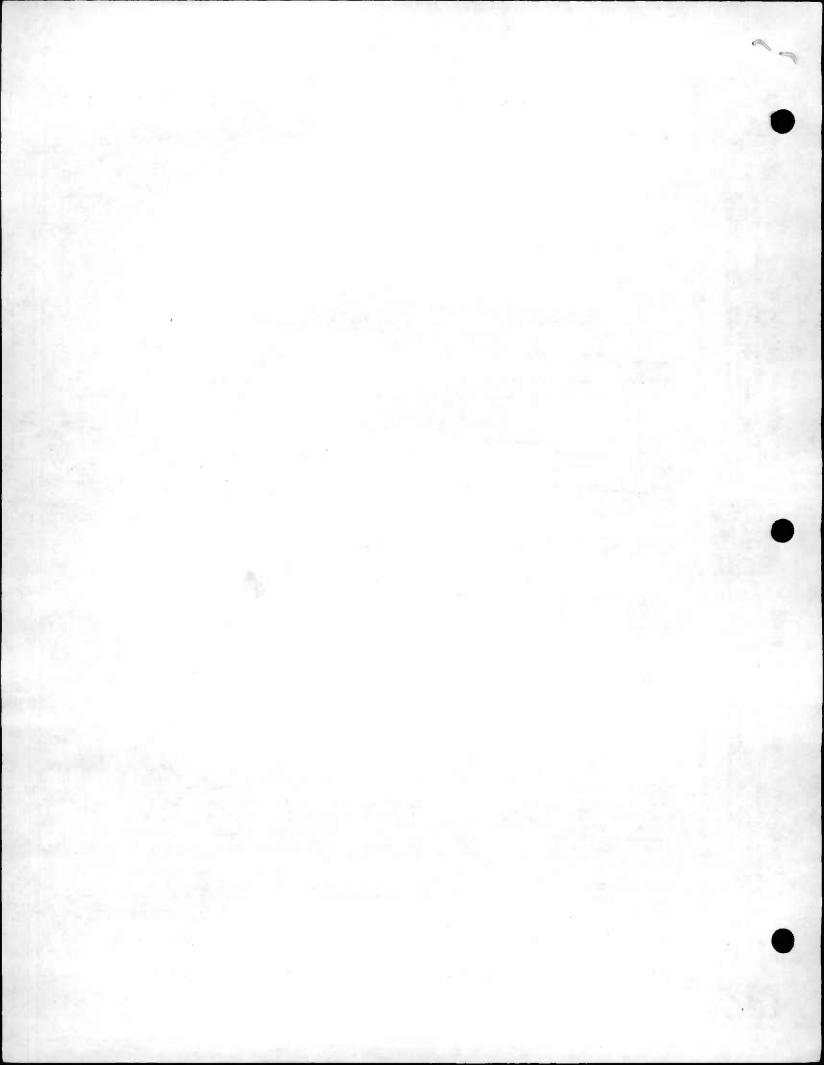
Catherine A. Picken, M.D. 3800 Reservior Road, N.W. Washington, D.C. 20007 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

D 17380

29d. Date signed (Month, Dey, Year) April 24, 2000



### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death APPIL 0422 2000 Albert William Bee 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Death CHEVERLY PRINCE GEORGES GEORGES HOSPITAL CENTER PHNG 7. Age (In yrs. lest birthday) If Under 1 Year Months Deys If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 M 2□ F Yrs WV Nov. 12, 1925 233-34-1263 Usuet Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No Webster Webster Springs 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 112 Maple Street 26288 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 44-46 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usuet Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Technician Department Store 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Unknown Roxie Riffle 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 43255 Gum Spring Drive, Leonardtown, MD. 20650 20b. Place of Disposition (Neme of cemetery, crematory or other place) Dete Nov. 25 Albert Hickman-Daughter Dete 25 20a. Method of Disposition Nov. 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 2000 Webster Springs, WV. 4 ☐ Donetion 5 ☐ Other (Specify) Miller Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service Alexandria, VA. 22310 5517 Vine Street 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finet diseese or condition resulting in death) INJURIES WITH COMPLICATIONS Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of) thet Initieted events resulting in death) Lest Due to (or as e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 2 No 1 Yes 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1224

**Physician** /Medical Examiner requires thet the death certificate be executed

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Examinar inside a notified at

permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mental Hygiene. Important: If Itsm 27 is marked other than "natural", or item any injury or other treumetic event, the Medical Eventriest once.

 $\omega_{\mathcal{U}}$ Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital

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Examiner Physician/Medical þ Completed Be 10 Certification:

the attending physician to deteched à been signed be should be dete page 2 certificate hes

After this s efter death. in by Hospital or 24 hours To the Hosp within 24 hou To the Fune completely fi

4 Homicide

(Check only

MARIO =

31. Date tiled (Month, Dey, Year)

29a. Certifier

30. Na

State Registrar

Medical

1 Certifying Physician: To the best of my known Medical Examiner: On the basic of examination and manger stated. 29b. Signat

6 Could not be

GOLLE

04-13-00

(Type, Print)

Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

STREET 29c. License number

1 Yes

28d. Describe how injury occurred PRIVER OF VEHICLE INDIVED

IN COLUSION WITH ANOTHER VEHICLE Location (Street and Number or Rural Route Number, City or Town, State) RT235 & RT4 ST MARX'S COUNTY

te, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner as steted. 29d. Date signed (Month, Day, Year)

MINO, CHOUGREY MARKAND 20

HOSPITAL 32. Registrar's Signature

MANUAL STREET OF THE TAX

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Data of Death **Physician** 24, 2000 4c. County of Death 42 Emmitt Kent Bell, Jr. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LAUREL HOSPITAL REGIONAL AUREI PRINCE GEORGEX If Under 1 Year If Under 24 Hrs. 6. Sex 1 → M 2 □ F 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs 212-66-7929 Director 46 26, 1954 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 'natural', or itema 23a 503 Prince George's Avenue 20707 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Detes: 11 Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Black, White, etc. permit. Pages 1 end 2 should be filled within 72 hours after of Department of Health and Mental Hyglene. Interchant: if Item 27 is marked other than "natural", or the limportant: if Item 27 is marked other than "natural", or the any injury or other traumatic svent, the Medical Examinations. 1 □ Never Merried 2 □ Merried Baitimore, Marviand 21215-0020 1 ☐ Yes 2 No Specify Specify: þ 3 □ Widowed 4 ₺ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) College (1-4or 5+) 12 Sales Person Retail 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be Emmitt Kent Bell, Sr. Edytha Jewel Goepferich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. tnforment's Name/Reletionship (Type, Print) Robin Bell/Sister 1341 Hemlock Street, N.W., Washington, D.C. Apr.27 20b. Plece of Disposition (Neme of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ØCremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Euneral Service Licens Bethesda-Chevy Chase, Inc. 755 Bethesda, Maryland 20814-3501 M00803 23a. Pert1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in daath) HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE Examiner Dua to (or as a consequence of) Examiner physicien and as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): signed by the ai Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Vunknown Records. þ 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of deeth? 1 🗆 Yes 1 ☐ Yes 2 ☐ No certificeta Division of Vital or Attending Physician: director. Be 25. Wes case referred to medical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2□ No 2 VER/Outpatient 3□ DOA 1 Inpatient this After this funeral 27. Mannar of Death 28a. Data of Injury (Month, Dev Year) 28b Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation Naturel
2 Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 Certifying Physician: To tha best of my knowledga, death occurred at the tima, date end pleca, end due to the ceuse(s) end menner as steted. 22 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, daeth occurred et the tima, date end placa, end due to tha cause(s) and manner sturied. (Check only one)

State Registrar

29b. Signatu

30. Name and address of person who come

GOVLE

APR 28 2000

MARIO #

31. Deta filed (Month, Day, Year)

2001

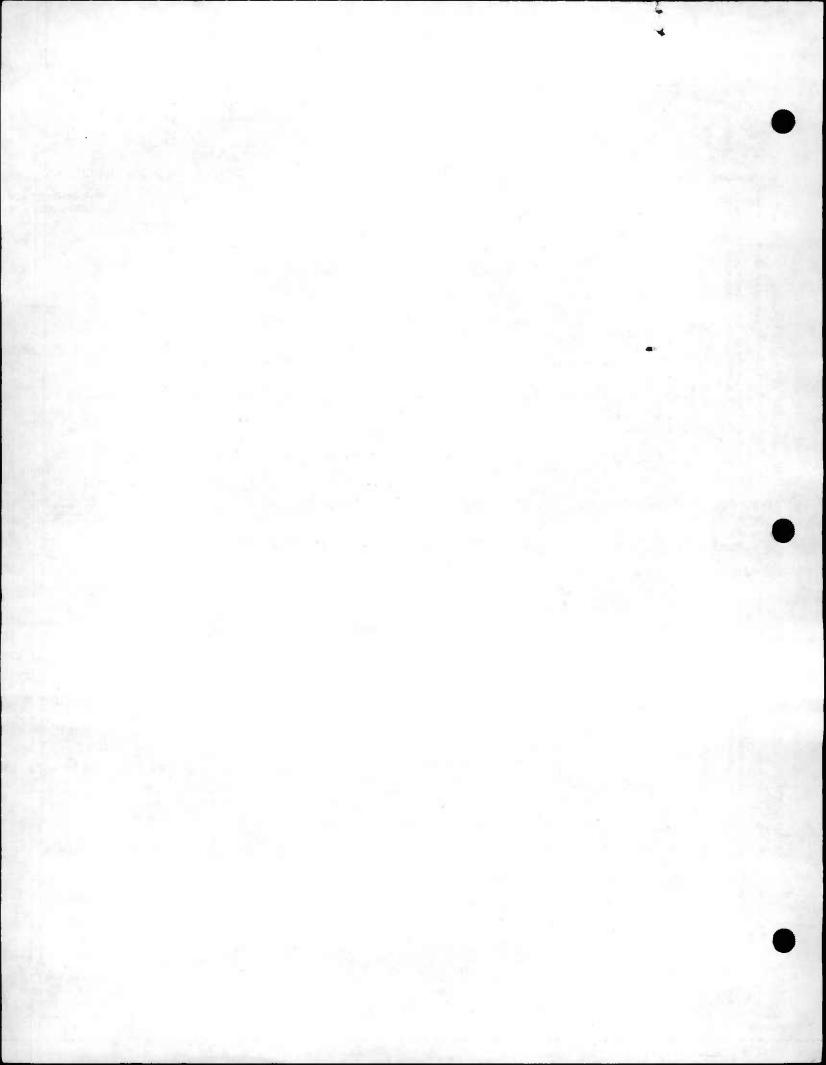
suse of deathy (Jem 23a) (Type, Print)

32. Registrer's Signeture

29c. License numbe

WIVE

29d. Date signed (Month, Dey, Year)



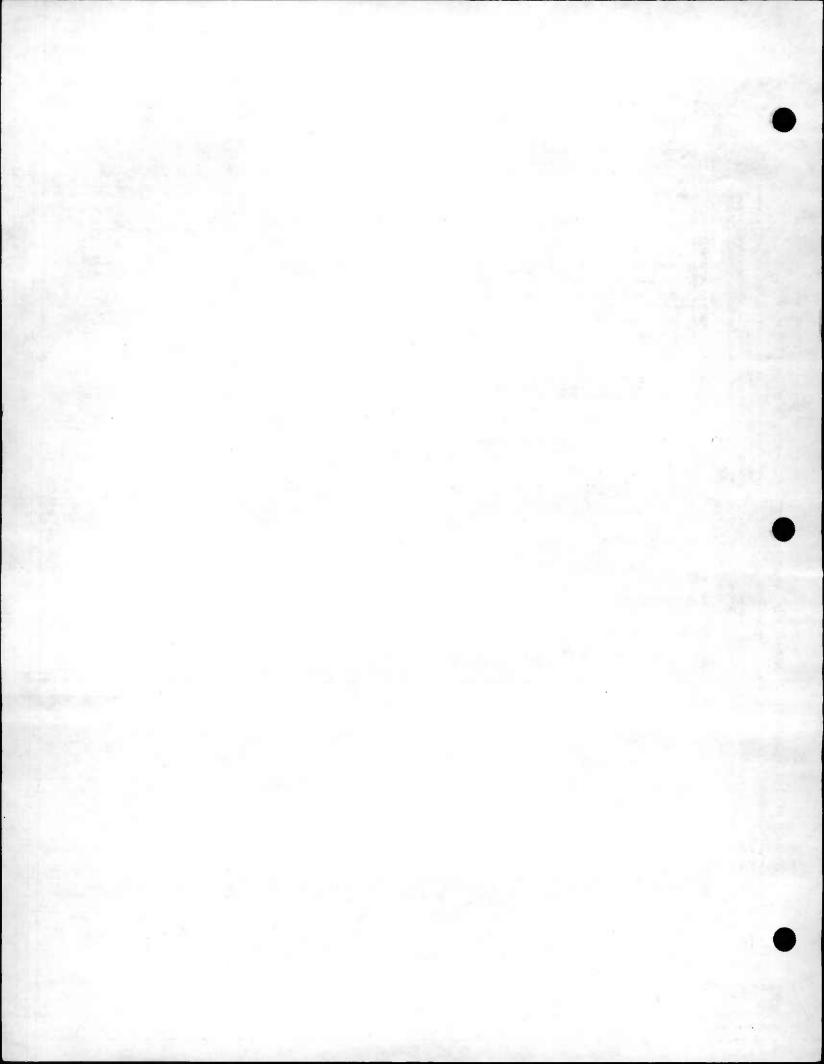
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** April 24, Margaret C. Borden 2000 4:20 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 M 2 F Yrs 99 Director 578-34-3236 Sept. 4,1900 Virginia **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahor the Medical Examinar must be notified at 1 W Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? USA death y Funeral 11371 Columbia Pike 20904 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: à 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry lith and Mantal Hygiene. 27 is marked other than 'r r traumatic event, me Med Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home Baltimore, Maryland permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Nem 27 is marked orbit any Injury or other treumatic event, plate. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Joseph Frank Sorrell Laura Coletta Money 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5920 Frazier Lane McLean, Virginia Ralph L. Borden 22101 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Browns Chapel Cemetery 4/27/00 Reston, Virginia 21. Signature di Funeral Service Licen-22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Sep 875 Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certifloate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettanding physicien I for use as the burle Due to (or as a consequence of) P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use/contribute to the cause of death? 4 3 Probably 4 Unknown 1 Yes 2 No ate has been signed , page 2 should be dat Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy this certificate has 1 Yes 1 ☐ Yes 2 ☐ No of Vital tal or Attanding Physicien: The sefar deeth.

Signature of the properties of the sefar deeth.

In part of the sefar the sefar of the sefar deeth. 25. Was case referred to medical 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 12 Inpetient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending investigation 1 TYes 2 No 2 Accident ne Hospital or Atta no 24 hours efter de ne Funerel Directo pletaly filled in by th 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil edical 29a. Certifier 29d. Date signed (Month, Day, Year) APRIL 24, 2 29c. License number 29b. Signature and title of certified ROCKULLE PILLE HELT ROCKULTE WEST use of death (Item 23a) (Type, Print) 31. Date filed (Mgg State Registrar



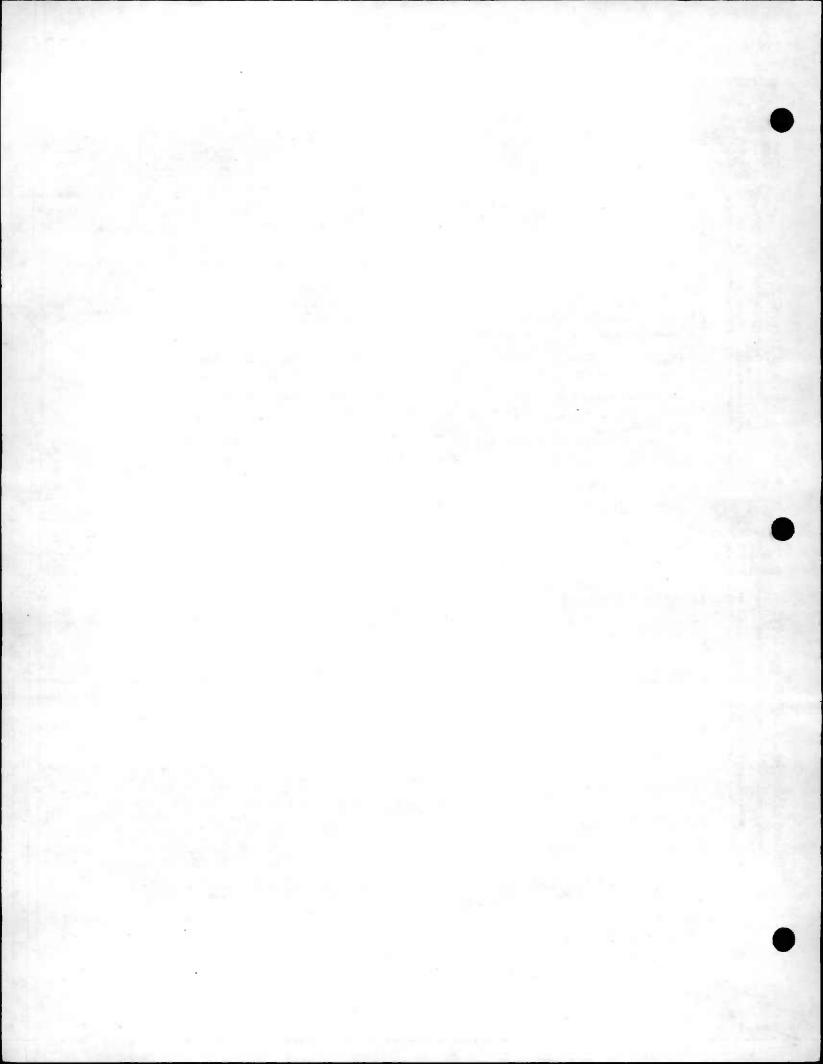
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State of Maryland / Department of Health and Mental Hygiene

14936

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aminer	4a Facility Nama (If not instituti SHADY GROV			SPITA	ΔL		City, To		cation of Deat		of Death	MERY
l r	5. Social Security Number 281-46-2848	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 98	last birthday) Yrs.	If Under 1 Ye Months Da	ear	If Under Hours		8. Data of Bi (Month, Di NOVEME	th	9. Birtho	place (Stata or Foreign http:) ELGIUM
_	Usual Rasidence of Decedant  10a. Stata  10b. Count			y, Town or Lo							1	10d. Inside City Limits
Director	MARYLAND MONTG	OMERY	MON	TGOMER	Y VILLA							1 □ Yas 2 No
į	10e. Street and Number				10f. Zip Cod	ie				10g. Citizen of	What Cour	ntry?
	10504 SENECA R 11. Marital Status 1 Never Merried 2 Ma	12. Was De Armed F 1 ☐ Yas	cedent Evar in U, Forces? 27 No Give A		20886 Vas Decedent I Yes, specify C	of His Cuban		gin? (Spe i, Puerto	ecify Yas or No Rican, atc.)		ck, White,	can Indian, atc.
	3 Widowed 4 □ Divorce	d Year or	Detas:							Specif	WHI	TE
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	17. Fathar's Name (First, Middle ALPHONSE DANSE	n, Last)							(First, Middle LISSOI	, <i>Maiden Suman</i> R	na)	
	19a. Informant's Name/Ralation			19b. Mailin	g Address (Str	eet ar	nd Numbe	or or Rura	al Route Numb	er, City or Town,	Stata, Zip	Code)
1	PAULETTE A. SK	ALKA/ DAUG					IDGE,	MON		Y VILLA		
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	21. Signature of Juneral Service	Licensee			Nama and Ad ERVICES			STA	VENUE	RAL & CI	SEMAT	TON G,MD
	23a. Partf. Entar tha disaesa, shock, or haart failure. Lis fmmediata Cause (Final diseesa or condition rasulting in daath)	a Bo	₩ €		RUCT			cardiac c	or respiratory e	rrest,		Approximata Interval Between Onset and Death
	Sequantially list conditions, if any, leading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last	6. <u>D1</u>	VERT	res e consequ 7 CV C as a consequ	0515	•					1	
	Part It. Other significant condit	d	death but not resu	ulting in the un	nderlying cause	giver	n in Part f.			tobacco use co		o the cause of death?
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									10	Yes 25 No	10	Tas 2□ No
	25. Was casa rafarred to medic		,					of Death	(Check only	one)	-	
	1 ☐ Yas 2 ☑ No 27. Manner of Deeth			ER/Outpatient	3LI DOA	Other	4LI NU			dence 6 Oth		(v)
	1 ☑ Natural 5 ☐ Pandi 2 ☐ Accident invasi 3 ☐ Suicide 6 ☐ Could	I not be	a of Injury nth, Day Year)	28b. Tima of Injury		I 🗆 Y	et ? es 2□I	No	28f. Location (	how injury occur Street and Numi		al Routa Number,
	29a. Cartifiar 12 Certifyi	ng Physician: To the	a best of my know	wledge, death	occurred at the	e tima	ı, data anı	d place, e	end dua to the	causa(s) and m	annar es s	tated.
Medical	one) 2 Medica 29b. Signaline and title of certific	- /	basis of axaminat pnar stated.	ion and/or inv	estigation, in m			in occurr	ed at the time,			
	LOD. SIGNAL AND BUILDING	all. L.V	1					3		29d. Date signs		
-	30. Name end eddress of person	who completed com	ISO of dooth flor-	23a) /Time *	Drint)	))	///	/		MPRIL	06	, 2000
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 493 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Lillian E. Briggs 21, April 2
4b. City, Town, or Location of Death 2000 10:55am /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Montgomery General Hospital Olney
If Under 24 Hrs. Montoomery
9. Birthplace (Stata or Foreign Country) If Linder 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Vrs Director 438-01-8975 83 Nov. 30,1916 Texas Usuel Residence of Decedent the Marylend permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner rount be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20906

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15015 Haslemere Court 14. Raca - American Indian, 12. Was Decedent Ever In U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 287 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grade complated) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middla, Last) Be 2 James Kev Della\_ Lemelle 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Typa, Print) Silver Spring, Maryland Dete | 20c. Location - City or Town, State Douglas Briggs (husband) 15015 Haslemere Court 20b. Placa of Disposition (Nama of camatary, cramatory or othar placa) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr.24 4 Donation 5 Dother (Spacif) Entombment Gate of Heaven Cemetery 2000 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. dames 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Stroke, massive Examiner Due to (or as e consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): nding p signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown Insulin Dependent Diabetes 1 ☐ Yes 2 ☐ No Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been sig Completed 24a. Was an autopsy performed? is certificata hes b diractor, paga 2 s 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Wes case referred to medical 26. Piece of Death (Check only ona) examiner? Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

C. Ozanne-

31. Date filed (Month, Day, Yaar)

Blankford

APR 24 2000

WD

32. Registrar's Signature

Denwa

**DHMH 16 Rev 6/95** 

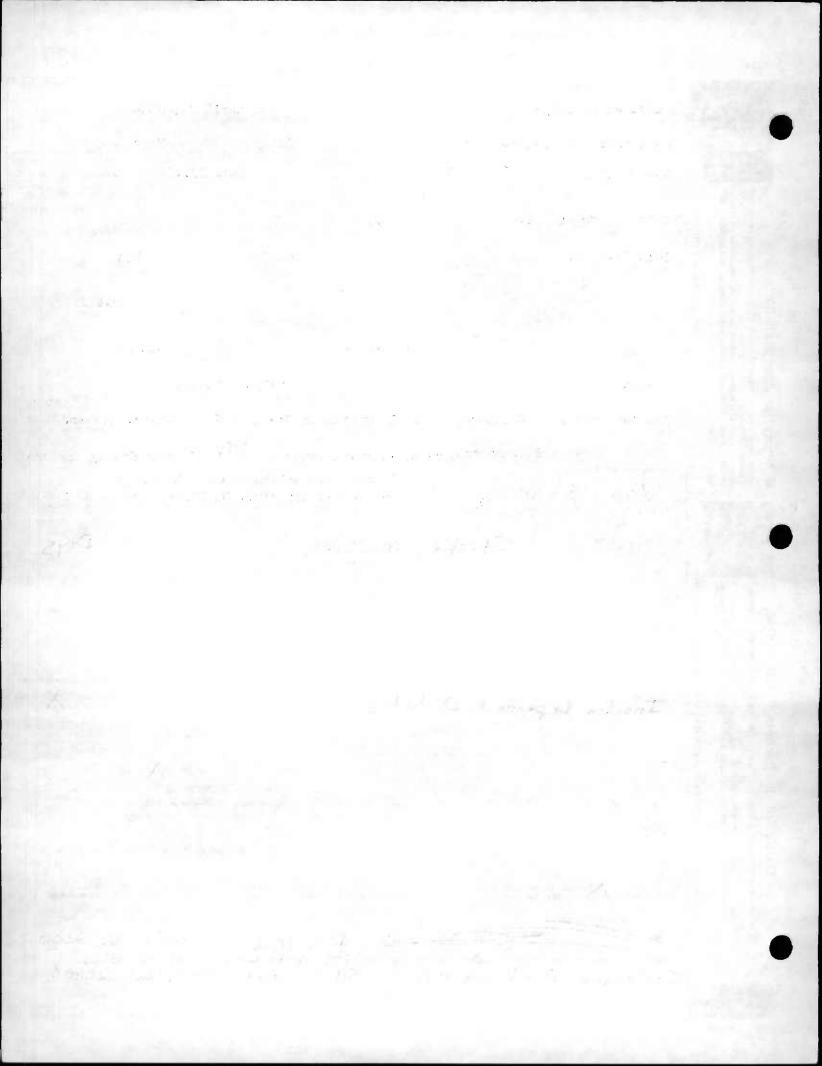
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29d. Date signed (Month, Day, Yaar) 29c. License number

9000

BING 30. Name and address of person who completed clime address (Item 23a) (Type, Print) 3 205 Worth Lewve World Silve Spring

mary land

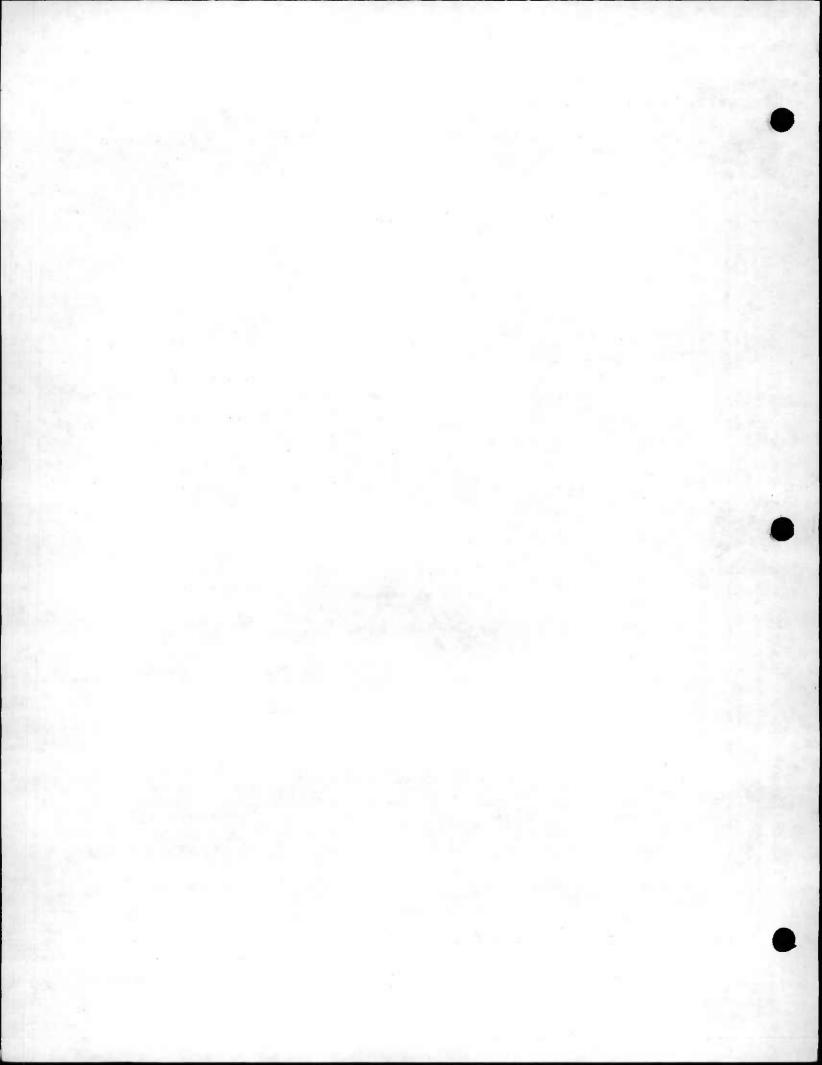


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month James A. Britton, Sr. 04 21 2000 10:15 a.m. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Casey House 6001 Muncaster Mill Road Rockville Montgomery If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Dey, 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1⊠M 2□ F Yrs 579-09-0107 Director 88 1911 Washington, DC Usuel Residenca of Decedent permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show sail fully or other traumatic avant, the Medical Evantical must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 HNo Funeral Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9106 2nd Avenue 20910 USA 12. Wes Decedent Ever in U.S.
Armed Forces?

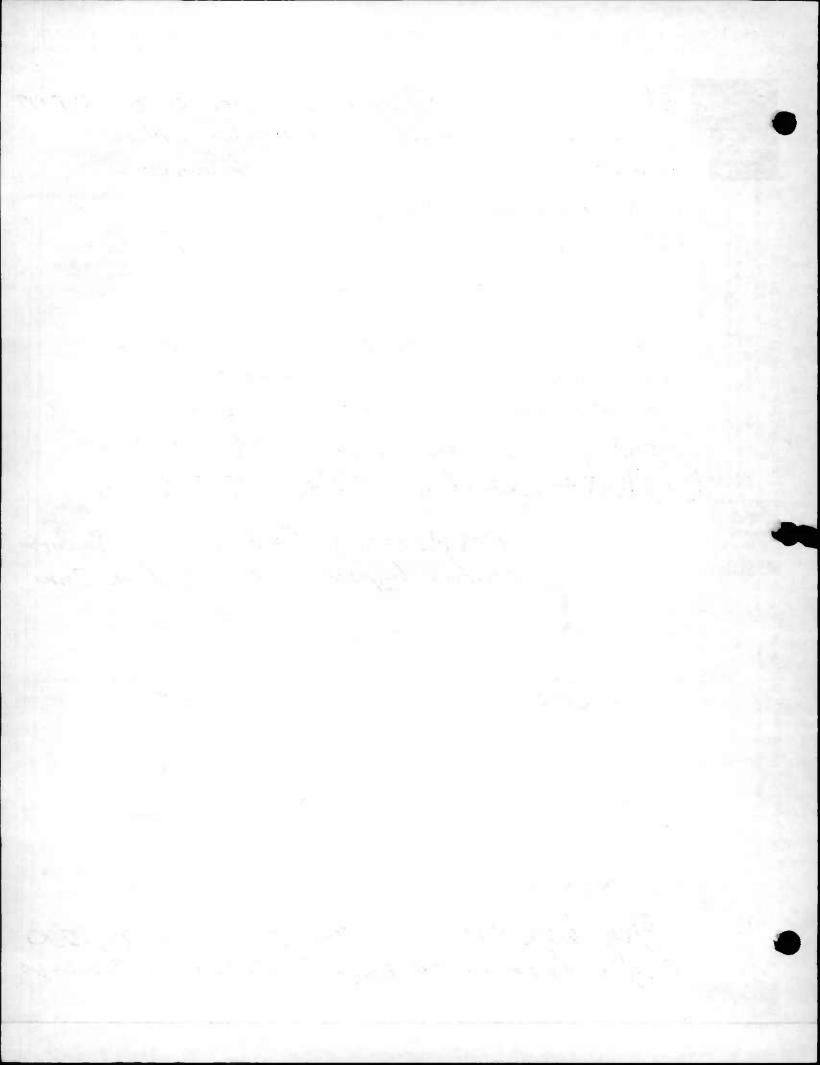
1 Mayes 20 No
If Yes, Give Year or Dates! u142-Sep 45 11 Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - Americen Indien. Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electrician Electrical 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Andrew Britton Mary A. Couglin 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Betty B. Britton / Wife 9106 2nd Ave, Silver Spring, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/24/00 | Silver Spring, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Francis J. Collins Funeral Home 500 University Blvd W. Silver Spring, MD 20901 trosal 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Mestastatic Mesothelioma 6 months Examiner Due to (or as a consequence of): Physician/Medical Examiner Mesothelioma of Lung 12 months The lew requires that the death certificate be executed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pue Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? cata hes been signed by page 2 should be detect tXXYes 2□ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2CXNo 1 ☐ Yes 2 ☐ No certificata Attending Physician: funeral director, 25. Was case referred to medicel 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6X2Other (SpecifyHOSpice Certification: To 1 Yes 2⊠ No 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Naturel 5 Pending after death. 1 Yes 2 No investigetion 2 Accident \$ 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1Excertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted. Medical 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D09470 April 21, 2000 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D., 10400 Connecticut Avenue, Kensington, MD 20895 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture 2 4 2000 APR Registrar



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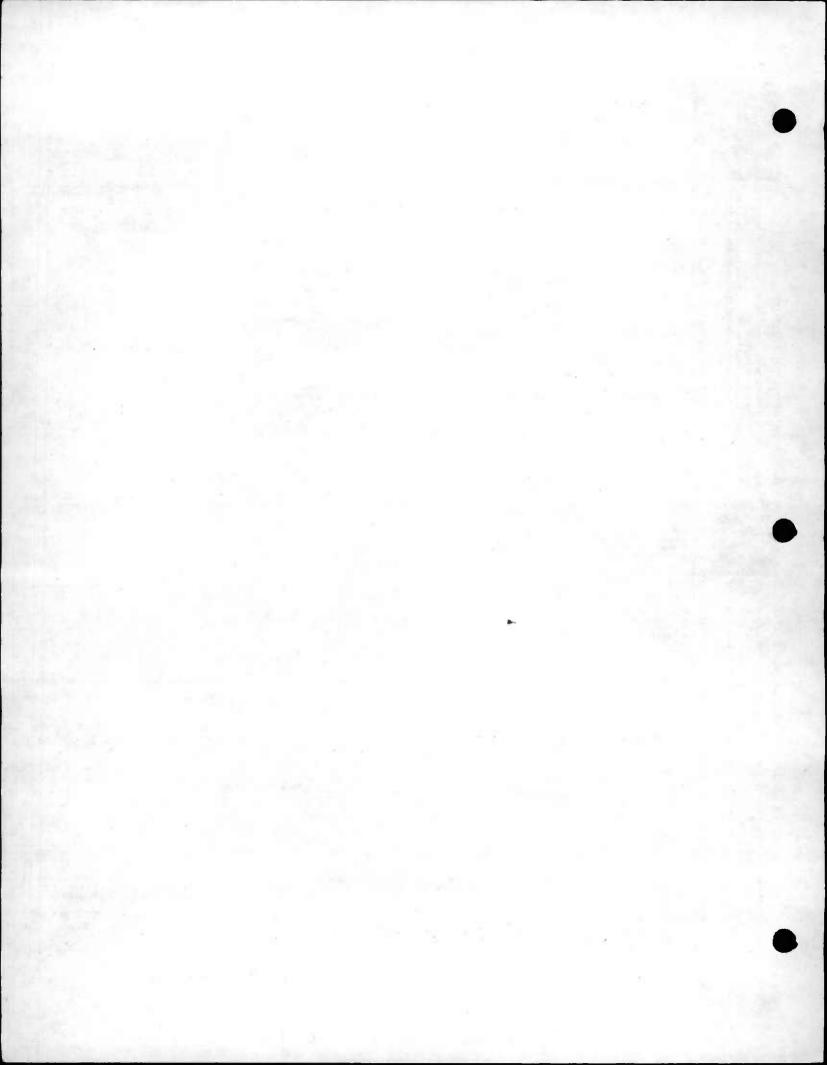
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	Funeral Director		5. Social Security Number  349-12-1132  Usuel Residence of Decedent	ge (In yrs. last bi		Under 1 Year onths Deys		(Month, D	th ey, Year) c 7, 1920	9. Birthpl Count IIII	lace (State o try) Lnois	r Foreign
	e Maryland	ctor	10a. Siele 10b. County Maryland Prince Georges	10c. City, Tow Laure	-	on				10	0d. Inside Ci	•
	th with th	Funeral Director	10e. Street end Number 14726 4th Street # 109		1	10f. Zip Code 207(	)7		10g. Citizen of W United			
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	d 2 shorth end N is men	-	19e. Informent's Name/Relationship (Type, Print) Anthony Doyle/ Attorney	l l	_		t end Number or Ru Patuxent				Code) 2104	4
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Balt	permit. Peg Department Important: I any injury o	(	21. Signatura of Funeral Service Licensee	ch	22. Na CO.	ame and Addr Lumbia	ess of Facility Mortuary	Service	es,Inc.	20025		
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כ	Physician /Medical Examiner	Examiner					Faci	hove toon	szudr	X+>C	Sun De	
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0	Physic this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati		•	BLJ DOA			denca 6 □Othe		)	
	Attending Physician: or death. sector: After this certific by the funeral director,	tion	27. Menner of Deeth  1 Natural  2 Pending  2 Accident    Accident		Time of Injury	28c. Inju Wo	ryet rk? ] Yes 2 □ No	28d. Describe	how Injury occurre	<b>3</b> 0		
Division	- 4	Certification:	3 Suicide 6 Could not be determined 28e. Place of In	jury - At home, fa tc. (Specify)	arm, street,		_	28f. Location ( City or To	Street end Numbe wn, Stete)	er or Rurel	Route Numb	ber,
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of end manner st	of examinetion en	e, deeth occ nd/or Investi	curred et the ti gation, in my	me, dete end plece oplnion, deeth occu	, end due to the rred at the time,	ceuse(s) end mer date end place, e	nner es ste ind due to	eted. the ceuse(s)	)
	To the within To the comple	Me	29b. Signature and little of cartified			29c. Licen	se number		29d. Date signed	(Month, L	Dey, Yeer)	
T.	5		De Name and add of the Way May	7	/T	109	1617		Apr.	24,	200	20
			30. Name end addfeds of person who completed ceuse of a COUS MILE TO	805 H	(Type, Print	buy K	ids K	16010	nensin.	Mel	2/09	14
	Sta	ite	31. Date filed (Month, Dey, Year) 32. Registi	rar's Signature	4	1	,					



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Holy Cross Hospital Silver Spring Montgomery				Cei	tificate of	Death		Reg. No.	U	4940.	
Charles A. Brown, Sr. April 16, 2000 12:55gm  Charles A. Brown, Sr.	Dhueirian	1. Decedent's Name (First, Middle, Last,							Year	3. Time of Death	
A Facility brains (first statistics, give states and number)  Holy Cross Robert (Sept of statistics, give states and number)  Holy Cross Robert (Sept of statistics)  Social Security Number (Sept of sta		Charles A	. Brown,	Sr.						12:56pm	
\$ Social Scorety Numbers   2 See   2 See   7 Age for you be inclined;   10 See   10	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
The control of the		Holy Cross Hospi	ta1			Silver	Spring	Mon	ntgome	ery	
Usual Flexiblement of Development   100. College	Funeral	- W	TAL OF E				8. Date of Birt (Month, Da	th y, Year)	9. Birthple	ece (State or Foreign	
The State   10c. State   10c. Cert   10c.	Director		11				Decemb	er 27,	1922	IC.	
3.2 Method at □ Devocade   Tester Chains   16e. Devoderly Unable Occupation   16e. Knot of Businesethidusiny   16e. Knot of Businesethidusiny   16e. Knot of Businesethidusiny   16e. Control of the Other State Chains   16e. Devoderly Unable Processing   16e. Devoderly Unable Processing   16e. Devoderly Unable Processing   16e. Devoderly Unable Processing   16e. Devoderly Unable Occupation   16e. Devoderly Unable Processing   16e.	G R		10c. C	City, Town or Lo	cation				10	d. Inside City Limits	
3.5 Percent   10   10   10   10   10   10   10   1	s Mary Milled a ctor	MD Prince	Georges	Edmo	nston						
3.5 Percent   10   10   10   10   10   10   10   1	death with the Maryland ms 23s or 28s-f show traust be notified at neral Director	10e. Street and Number 5056 Kenilworth	Avenue		10f. Zip Code	20781	l	-		•	
3.5 Percent of Control (1922)   16a. Decedent's Lisual Occapation (1924)   16b. Kind of Businessin/dullity	Der Cha	11. Marital Status	12. Was Decedent Ever in	U,S. 13.	Was Decedent of	Hispanic Origin? (S	ipecify Yes or No	- 14. Rac			
Specific of highest gries conditions (Specific of highest gries conditions) (Specific of highest gries) (Spe	natural", or the dical Examina		ty∏Yes 2☐No If Yes, Give				o ricari, etc.)				
Elementary/Secondary (6-12)   Codege (1-4or 5+)   Codege (1-4or 5+)   Codege (1-4or 5+)   Clerk   Clerk   Codege (1-4or 5+)   Clerk	atura Ical E	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occu	pation		16b. Kind of Bu	usiness/Ind	ustry	
17. Father's Name (First, MicKle, Latar)   18. Mashing Address (Sineer and Number or Paral Rock Name)   19. Mashing Address (Sineer and Number or Raral R	Die o			life.	DO NOT use retire	during most of wo	rking				
17. Father's Name (First, Modile, Master Summany)   18. Mather's Name (First, Modile, Master Summany)   19. Mather's Name (First, Modele, Master Summany)   19. Mather's Name (First, Modele, Master Summany)   19. Mather's Avenue - Pearl Green	the C		College (1 401 01)		Cler	k		Federa:	1 Gove	ernment	
4   Donation   Scientific   George Washington Cem.   4/21/00   Adelphi, MD   21. Signature of Financial Service Locarions   Adelphi, MD   22. Surplature of Financial Service Locarions   Adelphi, MD   23. Part I fore the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   24. Part I fore the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   25. Part I fore the disease, or complications that caused on each line.   26. Part I fore the disease, or complications that caused on each line.   27. Part I fore the disease, or complications that caused on each line.   28. Part I fore the disease, or complications that caused on the line of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   28. Part I fore the disease, or complications that caused on each line.   28. Part I fore the disease, or complications that caused on the line of the	othe rent.	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sumam	10)		
A   Donation   S   Dotter (Speechy)   George Washington Cem.   4/21/00   Adelphi, MD	9 0	Elliott Brown				Pearl	Green				
4   Donation   Science   George Washington Cem.   4/21/00   Adelphi, MD   21. Signature of furners service Licensee   22. Ame and Address of Facility R. N. Horton Co. Morticians, Inc.   32. Part Earle the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.   32. Part Earle the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.   32. Part Earle the disease, or complications that cause of each line.   33. Signature of furners of Cause (Final disease) or conditions of the conditions of t	7 is mar traumat										
4   Donation   Signature of Funds Service Licensee   A / 21/00   Adelphi, MD   21. Signature of Funds Service Licensee   A / 21/00   Adelphi, MD   22. Synature of Funds Service Licensee   A / 21/00   Adelphi, MD   23. Synature of Funds Service Licensee   A / 21/00   Adelphi, MD   24. Synature of Funds Service Licensee   A / 21/00   Adelphi, MD   25. Part Licensee   A / 21/00   Adelphi   26. Part Licensee   A / 21/00   Adelphi   26. Part Licensee   A / 21/00   Adelphi   26. Part Licensee   A / 21/00   Adelphi   26. Part Licensee   A / 21/00   27. Part Licensee   A / 21/00   28. Was case referred to medical   28	E 6	20a Method of Disnosition	20b.	Place of Dispo	sition (Name of	T	Date	20c Location -	City or Toy	wn. State	
23a. Parti. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory areast.	ury or o	1 X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	cemetery, crer	natory or other pla						
Column   C	2 2	21. Signature of Funeral Service License	89	22	Name end Addr	ess of Fecility	Mortici	ng Inc	•		
23a. Parti. First the disease, or complications that cause of each line   Approximate   Approximat	§ 8	A Y Y SE	ton								
Section   Perish   Consider   C		23a. Part1. Enter the disease, or compl	ications that caused the de	ath. Do not ent	er the mode of dy	ing, such es cardia	c or respiratory a	rrest,	10	Approximate	
Congestive Heart Failure    24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No 1		Due to (or es a consequence of):									
Congestive Heart Failure    24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   No   Year   an/Medical E	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.										
Congestive Heart Failure    24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No 1   Yes 2   No 1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   No   No   No   No   No   No	5 d 2	Pert II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause g	ven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death	
25. Was case referred to medical examiner?  1	Phy	Diabetes Mitrial	Valve Regur	gitatio	on		10	Yes 2□No	3 ☐ Prob	ebly 1 Unknow	
25. Was case referred to medical examiner?    1	eted b	Congestive Heart	Failure						con	ilable prior to npletion of cause	
25. Was case referred to medical examiner?    Continue    V Q							ه ۳۵۰۰	}			
29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	3 0								11	Yes 2∐ No	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and isotrops of person who completed cause of death (Item 23a) (Tipe, Print)  Lynne Diggs, M.D.  31. Date filled (Month, Day, Year)  32. Registrat's Signature  33. Registrat's Signature  29a. Certifier (Check only one)  29b. Signature and due to the cause(s) end menner as stated. (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  April 18, 2000	စ္တို့ က်ိဳ	examiner?	Anenital:		10		eth (Check only o	one)			
29a. Certifier (Check only one)  29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	2	TE TOS ZENO	1- Inpatient 21	1	N 3LI DOA	4 LI Nursing F	7			)	
29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner as stated.  29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  April 18, 2000  30. Name and address of person who completed cause of death (Name 23a) Type, Print)  Lynne Diggs, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901	atlon	1 ☑Natural 5 ☐ Pending	(Month, Day Year)				28d. Describe	how injury occur	red		
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (North Pay, Year)  Lynne Diggs, M.D.  31. Date filled (Month Day, Year)  32. Benistrar's Signature	entific	determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (: City or To	Street and Numb vn, Stete)	oer or Rural	Route Number,	
30. Name and actives of person who completed cause of death (Nem 23a) (Type, Print)  Lynne Diggs, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901	dical C	(Check only 2   Medical Exami	ner: On the basis of examin								
30. Name and accrets of person who completed cause of death (New 23a) (Type, Print)  Lynne Diggs, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901	E S	29b Signature and title of certifier	~		29c. Licen	se number		29d. Date signe	d (Month, L	Day, Year)	
30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)  Lynne Diggs, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901	i	when of	1000	0	-	D34472		April	18	2000	
Lynne Diggs, M.D. 1500 Forest Glen Road, Silver Spring, MD 20901	+	20 Name and Market		2201	Drinti	~~ 1.11.E		TALLE	. 10,	2000	
31 Date filed (Month Day Year) 32 Benistrar's Signature						Silver	Spring,	MD 2090	)1		
	State										

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4941 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yaar **Physician** LUE BULKINDINE DAVID APUL 18 2000 19=15 Hrs /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner # 709 HALFOND HDE Congruss AVE If Undar 1 Yaar | If Undar 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 12/22/1929 9. Birthplaca (Stata or Foraign Country) New Jersey 5. Social Security Number **Funeral** Days 1X M 2 F Yrs. Director 70 212-26-5735 Usual Residence of Decadent permit. Peges 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Macical Examiner must be notified at pince. 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Directo Harford Havre de Grace MD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 505 Congress Avenue Apt 709 21078 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 X Yas 2 □ No If Yas, Giva Year or Datas: 13. Was Dacedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 15. Dacedant's Education (Spacify only highest grada complated) 16e. Dacedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa retired) Elementary/Secondary (0-12) College (1-4or 5+) Smith Motor Co. GED Service Parts Man 18. Mothar's Nama (First, Middla, Maidan Sumema) 17. Father's Name (First, Middla, Last) Be Marion Moneomia Cloman 2 Donald William Burkindine 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 653 4th St., NE, Pulaski, VA 24301 Donna Lee Baker- Daughter 20b. Placa of Disposition (Nama of camatary, crametory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 4/24/00 West Chester, PA Ferris & Co. Inc. 21. Signature of Funeral Service Licensee 22. Nama end Addrass of Facility Mitchell-Smith Funeral Home, P.A. Home 123 S. Washington, Havre de Grace, MD 21078 23a. Fart1 Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** Immediate Causa (Final diseesa or condition rasulting in daath) /Medical awa Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physicien end for use es the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury Due to (or es e consequence of): that initiated avants rasulting in daath) Last Dua to (or as a consequence of). signed by the eld be deteched f Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Diabotes Mulhhy 1 Yes 2 No 3 Probably 4 Unknown ITPE þ 24b. Wara autopsy findings evailabla prior to complation of causa of daeth? been signature 24a. Was an autopsy Completed performad? l director, page 2 s 1 Yas 2 No 1 Tyas 2 M No Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28c. Injury et Work? 27. Mannar of Daath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural er death. rector: Af by the fu 1 Yes 2 No 2 Accidant 3 Suicida 6 Could not be detarmined 28a. Placa of Injury - At home, farm, street, factory, office building, afc. (Spacify) 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) Hospital or At 24 hours efter of Funeral Direct 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, daath occurred at the tima, data end pleca, and due to tha causa(s) and mannar es stetad. 2 Amedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and placa, and due to the causa(s) and manner stated. 29a. Certifiar edical 29c. Licansa number 29d. Deta signed (Month, Day, Year) 29b. Signetura and titla of certifiar

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar 31. Data filed (Month, Day, Yaer) 32, Ragin

GPRASHO MD

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

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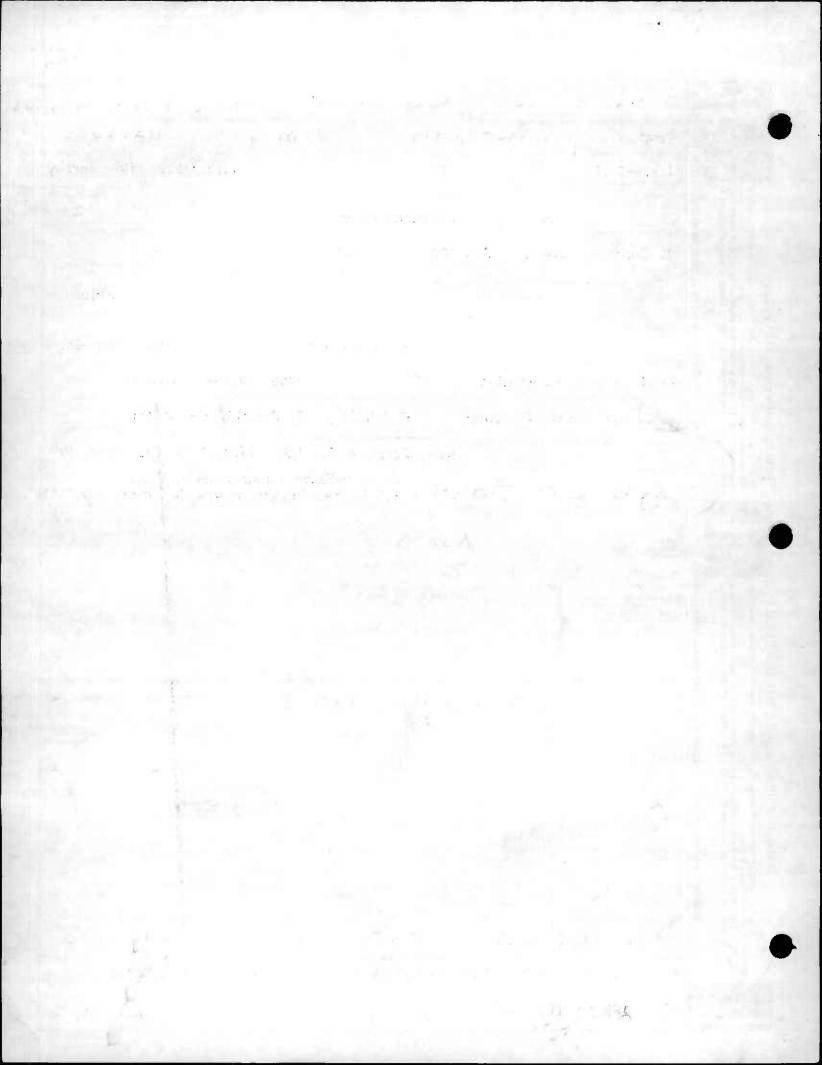
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DHMH 16 Rev 6/95



### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Yea **Physician** Robert WILBUR Bosley April 23rd 2000 6:00am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sax 8. Date of Birth (Month, Day, Year) Jan 7,1916 9. Birthplace (Stete or Foreign Country) Maryland **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 214-03-0234 Director 84 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Lower Beckleysville Road 21074 USA 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 ☑ Yes 2 ☐ No 1 Never Married 2 Married White If Yes, Give Year or Detes: 1 Yes 2 No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced WII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman's Union Longshoreman permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygier Important: if Item 27 is marked other th eny Injury or other treumatic event, the 2008. 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Grayson Bosley Ivy Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Paul, daughter 4515 Lower Beckleysville Rd, Hampstead, MD 21074 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bosley Cemetery 4/26 Butler, MD 21. Signature of Funeral Service Licenseel 22. Name end Address of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 24 hrs Physician/Medical Examiner Cere bro vascular Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last entricular à Completed 8

or Attending Physicien: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ete hes been signed by the e page 2 should be deteched i Medical Certification: To To the Hospital or much within 24 hours effer death.
To the Funerel Director; After manufactly filled in by the fur

Examiner

filed within 72 hours efter deeth with the Meryland

Baitimore, Maryland 21215-0020

Name 23a or 28a-f above the must be notified at

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Hygiene.

33311 g #1 3341 j E		d				
Part II. Other signific	cant conditions co	ntributing to death but not ras	ulting in the underlying ca	use given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death?
					24a. Wes an autopsy performed?	24b. Ware eutopsy findings eveilable prior to completion of causa of death?
					1 ☐ Yes 2 No	1 ☐ Yes 2 No
25. Was case referre examples?	ed to medicat			26. Place of De	eath (Check only one)	
1 Yes 2□ N	No I	Hospitel: 1 Inpatient 2	ER/Outpatient 3 DO	A Other: 4□ Nursing	Home 5 ☐ Residence 6 ☐ Oth	er (Specify)
7. Manner of Death  1 Manual  2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory,	office	28f. Location (Street and Numb City or Town, State)	per or Rurel Route Number,
29a. Certifier	1 Certifying Phys	sician: To the best of my kno	wledge, death occurred a	t the time, date end plac	e, end due to the cause(s) end ma	anner es stated.

State Registrar 29b. Signeture and

31. Date filed (Month, Day, Year)

APR 25

200 32. Registrer's Signeture

ted cause of death (Item 23a) (Type, Print)

Memorial Avenue Westminster MD 21857

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted.

29c. License number

D38993

29d. Date signed (Month, Day, Year)

Acres & Treated and the state of t

Baltimore, Maryland 21215-0020

Examiner Box 68760. P.O. | Records, of Vital Division

buriel-trensi death certificate be the pege 2 s certificate director. After this death. filled in by the To the Hospital within 24 hours e To the Funeral C completely filled

Physician/Medical Examiner by Completed Be 10 Certification: edical

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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**Funeral** 

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7 is marked other than "natural", or itema 23a or 28a-f traumatic event, the Modical Examinar must be notifie

permit. Pages 1 end 2 should be flig Department of Health end Mentel Hy, Important: if item 27 is marked othe any Injury or other traumatic evens

**Physician** 

/Medical

the Meryland

deeth with

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

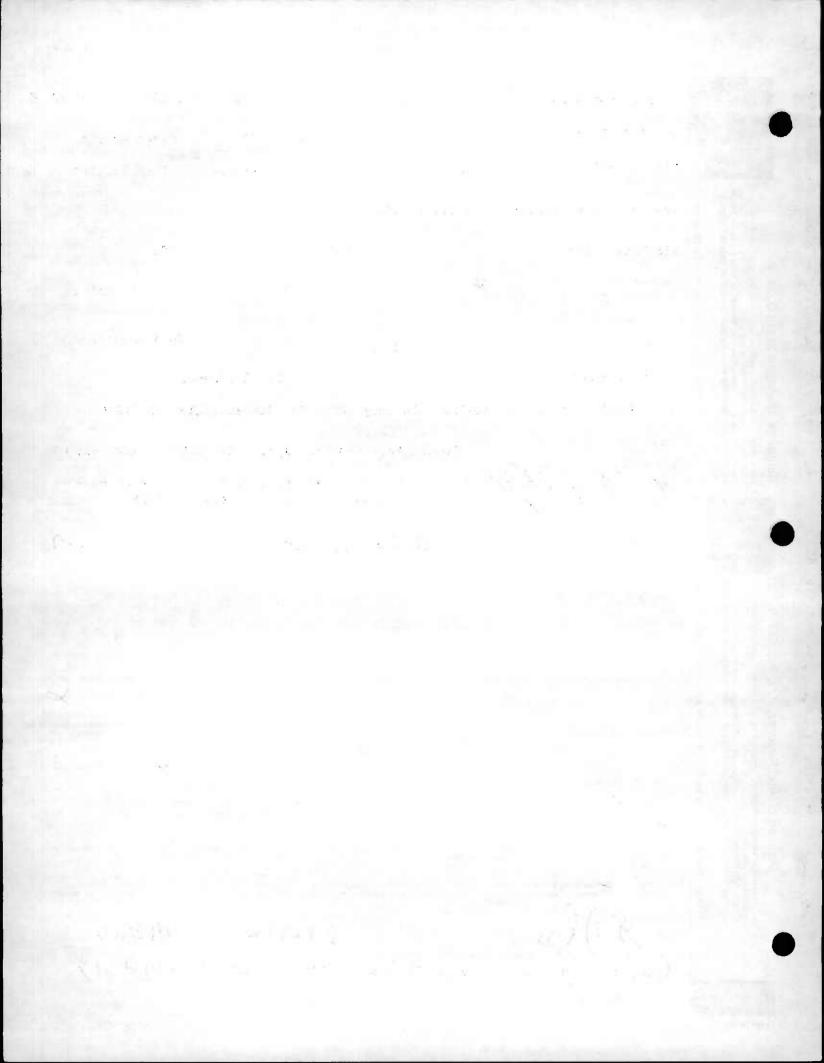
| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature/and title of 29c. License number 29d. Date signed (Month, Day, Year) 4/18/000 032036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2108 Di Dorato Drive Cheste, MO 2/6/9 31. Date filed (Month, Day, Yee) 32. Registrar's Signature

State Registrar

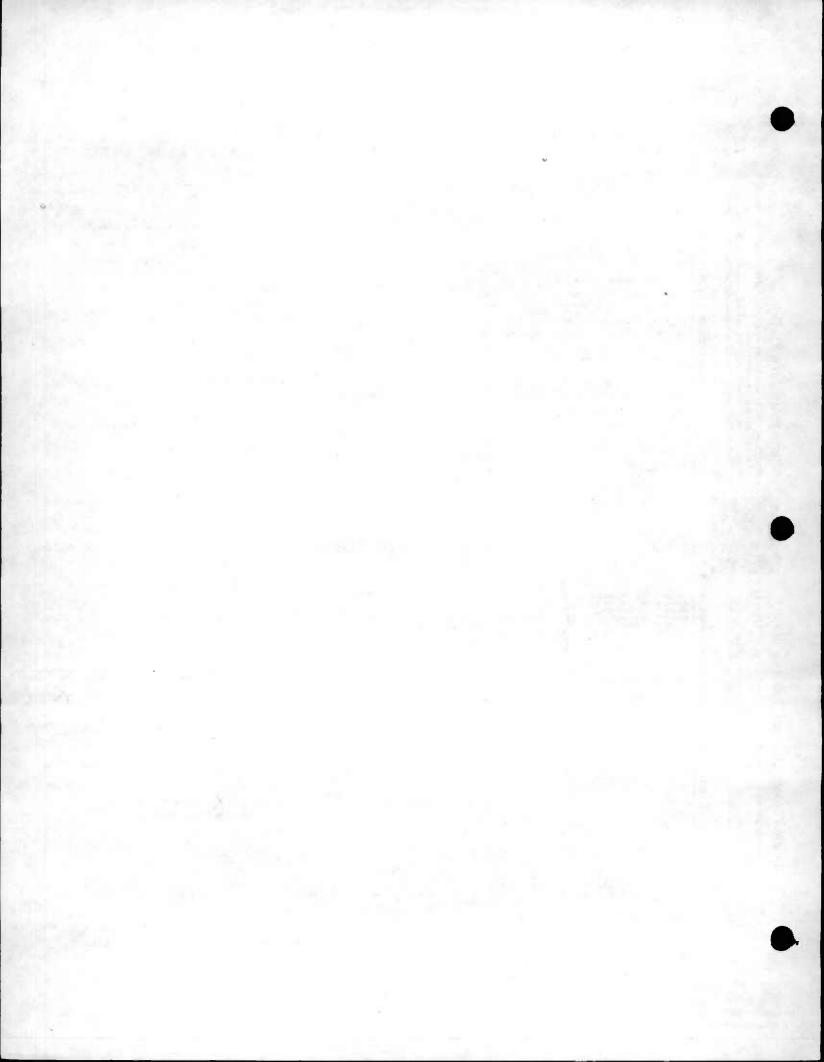
APR 19



# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

				ui yiuii	•	ficate of	Death		Reg. No.	00	1494	L
Physic	ian	Decedent's Name (First, Middle, La	st)					2. Date of Dea	Day	Year	3. Time of Dea	
/Medi			onio		stillo,	Sr.		April	24, 20		9:20 p	.m.
Exami	ner	4a Facility Name (If not institution, give	e street and number)			200	4b. City, Town, or					
- No.		39425 Thomas Dr					Mechanic		St. M			
Funeral		5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. l	M	Under 1 Yaar lonths Days	If Under 24 Hrs. Hours Min.	(Month, Da	h y, Year)	9. Birthpl Coun	lace (Stata or Fo	oraign
Director		579-22-6179	M ZEJT	8	4 Yrs.			June 2,	1915	Puert	o Rico	
D.		Usual Residence of Decedent  10a. Stata 10b. County		10c City	. Town or Locati	ion				14	0d. Inside City Li	imite
aryla aho	7	Too. Oodiny		Tou. Only	, TOWN OF LOCAL	NOT .				[ "	1 ☐ Yes 2 ■	
N Par	Ç	Maryland St. Mar	y's	Mech	anicsvi.							<b>B</b> 140
£ 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \			
23 at	8	39425 Thomas Driv	e			2065			United	State	S	
d 21215-0020  Illed within 72 hours after death with the Maryland Hyglane. The Transfer them 23s or 28s-f show out, the Medical Examiner must be notified as	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,	S. 13. Was	Decedent of I	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Rad Blad	a - America ck, Whita, o		
20 8	Y	1 Never Married 2 Married	1 ☐ Yes 2 🚮	No			Specify:Pue			Hisp	anic	
Naryland 21215-002 2 should be filed within 72 hours and Mentel Hyglene. Is marked other than "naturel;" raumatic event, the Medical Exa	d by	3 ■ Widowed 4 □ Divorced	Year or Dates:				. ,1 uc.	TEO RICA				
15-0 72 ho 72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Decedent (Give kind	's Usual Occup d of work done	pation during most of word)	rking	16b. Kind of B	usiness/Ind	ustry	
21215-0020 d within 72 hours aft glane. or than "naturel", or the Medical Energy	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)								-11
Syles A	S		2		Photog	grapher	1				f Agric	ultı
Maryland d 2 should be file th and Mentel Hy 7 is marked oth traumatic event	Be	17. Father's Nama (First, Middle, Last)					18. Mothar's Nar	ma (First, Middla,	Maiden Suman	na)		
Vid Men Men Men Men Men Men Men Men Men Men	To	Tomas Castillo					Matilde	Dividu				
and and		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailing A	ddress (Street	and Number or Ru	ıral Route Numbi	er, City or Town,	State, Zip	Code)	
and and alth		Elaine Ohler / Da	ughter		39425	Thomas	Drive, Me	echanics	ville, l	Mary1	and 206	59
Baitimore, Maryland 212: pernit. Pages 1 and 2 ahould be filed within Department of Health and Mentel Hygiane. Important: if tem 27 is merked other than and minity or other traumatic event, the Medics.		20a. Mathod of Disposition		-	aca of Disposition	on (Name of	ce)	Date	20c. Location -	City or To	wn, State	
Pages nent of P mt: If ite ury or of		1  Burial 2  Cremation 3  4  Donation 5  Other (Specif			dar Hill			4-28-00	Suitlan	d. Ma	rvland	
Baitimore, semit. Pages 1 ar Separtment of Hea mportant: if item into injury or other title.		21. Signature of uneral Service Licer	A 0/	1,00	22. Na	ame and Addre	ess of Facility				1 y 1 u ii u	
Ba Pem Impo		Vallud 11 2	TWA	1			d-Echols					
_		Edward N. Brin					ee Notch			Hall		22_
		23a. Part1. Entar tha disease, or com shock, or heart failure. List only	one cause on aach li	ne.	. Do not enter th	ne mode of dyl	ng, such as cardia	c or respiratory a	rast,	1	Approximate Intarval Betwee Onset and Deal	eth.
Physician			_	,						1	/	
/ /Medical Examiner		Immediata Causa (Final disease or condition resulting in death)	a. Gas	itric	curc	Inamo	^			1	6 mas	
Constitution in		resulting in death)		Due to (or	as a consequer	nce of):						
P #	<u>1</u>		h							i		
I Records, P.O. Box 68760,  The law requires that the death carlificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burist-transit	edicai Examiner	Sequentially list conditions,	0.	Due to (or	as a consequen	nce of):				1		
slan a	E E	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury							1			
68760, ifficate be ext g physician as the buriel.	Ca	that initiated events resulting in death) Last	С.	Dua to (or	as a consequen	ce of):				1		- 10
nd lies	-									1		
ds, P.O. Box ires that the death cer signed by the attendir d be detached for use	Physician/N		d									
daal daal	CI	Part II. Other significant conditions of	ontributing to death b	ut not resu	iting in the under	rtvina cause oi	ven in Part I.	23b, Did 1	obacco use co	ntribute to	the cause of de	eath?
O by the letache	Į,					,		10	Yes 2 No	3 □ Prob	onbly 4 Unit	known
the ded	by P											
Records, na law requires the new seen signe	ğ	0.000							an autopsy		era autopsy findi	ngs
cord v require been si	Completed							perfo	rmed?	cor	ailable prior to impletion of cause death?	0
hes be 2 80 2 80 2 80 2 80 2 80 2 80 2 80 2 8	E								V.	OI C		
cate								101	es 2 No	1	Yes 2□ No	
Vital Rec sicien: The law certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Massital:			100		ath (Check only o	ne)			
Physi rithis o	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatient	3LI DON		lome 5 Resid			)	
ng P	ü	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe I	now injury occur	red		
Division  I or Attending after death.  Director: After d in by the fune	ati	2 ☐ Accident investigation				M 1	Yas 2 □ No					
IVIS ar de recto	#	3 Suicide 6 Could not b 4 Homicide determined	28e. Placa of Inj	ury - At hou	me, farm, street,	factory, offica		28f. Location (S City or Tox		er or Rura	l Route Number,	
Division of Vital Re To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:		January, et	_ (Sp.Sony)	750							
hour hour ner		29a. Certifier 12 Certifying Ph	vsician: To the best	of my know	rledge, death oc	curred at the ti	ma, data and place	, and due to tha	causa(s) and ma	annar as st	ated.	
P Fu	edicai	(Check only 2   Medical Examone)	iner: On the basis of and manner st	l examinati ated.	on and/or invest	igation, in my o	opinion, daath occu	irred at the time,	date and placa,	and dua to	tha cause(s)	
To the	ž	29b. Signatury and little of certifier	11			29c. Licens	se number		29d. Date signe	d (Month, I	Day, Year)	
1. 2 P. 0		1/1 has // //	11			D:	9979	100	4/7	6/1	1)	
		20 Name and address of	m	loath /#	22a) (Trans. D.)	100			110	-010	U	
		30. Name and address of person who					Dood I.	onordes	n Marri	land	20650	
		William K. Kelly 31. Data filed (Month, Day, Year)	, M.D., 2			ookout	Road, Le	onarutow	n, rary	Lanu	20000	
Sta Registr		ADD 0 0		ars Signal	~ 4	1						

DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	4. December 14 Name / Films Addition 1			- Crimodic	of Death	O Date of Da	Reg. No.	3. Tima of Death
Physician	Decedant's Nama (First, Middla, L.					2. Data of Da Month	Day	Yaar
/Medical	Rita Patricia C				at Oh. To		24, 2000	1:30 am
Examiner	4a Facility Name (If not institution, gi	va street and number)				wn, or Location of Deat	h 4c. County o	or Death
	Mariner Health				Kensi	ngton	Montg	
Funeral	.,	Sax 7. Aga 1 □ M 2 ⊠ F	(In yrs. last birtho	Months	1 Yaar   If Undar 2 Days   Hours	Min. (Month, D.	rth ay, Year)	<ol> <li>Birthplace (Stete or Fora Country)</li> </ol>
Director	530-14-2703	10 10 2421	87 Yr	S.		March	17,1913	Washington,DC
0	Usual Rasidance of Decedent  10a. Stata 10b. County		10c. City, Town o	or Location				10d. Insida City Lim
short short	Too. County							1 ₽ Yas 2 □ I
or 28a-f s	Maryland Montgo	mery	Kensing					41
or 2	10e. Street and Number			10f. Zip	Coda		10g. Citizen of W	hat Country?
ath with the Marylan 23e or 23e-f show Let be notified at rai Director	10231 Carroll P	lace			20895		USA	
filed within 72 hours after death with the Maryland they than "natural", or items 23s or 28s-f show not, the Medical Exerticer must be notified at the Completed by Funeral Director.	11. Marital Status	12. Was Decedant Ev Armed Forcas?	ver in U,S.	13. Was Deceda	ant of Hispanic Orlo	gin? (Specify Yas or N , Puarto Rican, atc.)	0- 14. Race	- Amarican Indian, , Whita, atc.
or he	1 ☑ Nevar Marriad 2 ☐ Married	1 ☐ Yas 2 No If Yas, Giva	)		No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	, viina, aro.
ref., o	3 Widowed 4 Divorced	Yaar or Datas:			. В то оросту.		Зреспу.	White
ed within 72 hours ygiena. Ner than "natural", ft, the Medical Exe Completed by	15. Decedent's E (Specify only highast gr		16a. D	ecedent's Usual	Occupation	of working	16b. Kind of Bus	sinass/Industry
ple and	Elamantary/Secondary (0-12)	Collega (1-4or 5+	·)	ife. DO NOT us	k dona during most a ratired)	or working		
Hygiena. rther than ent, the M	12			ner			Restaur	ant
d other Hyger and other an	17. Fathar's Name (First, Middle, Last	()			18. Motha	r's Nama (First, Middle	, Maiden Sumame	a)
	Thomas A. Canno	n			Eth	el B. Harr	ison	
d 2 should be the and Mental if T is marked on treumatic eve	19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·	19b. N	Mailing Addrass	(Street and Numba	r or Rural Routa Numi	per, City or Town, S	Stete, Zip Coda) 20815
ith a 17 is 17 is	Thomas A. Canno	n (nephe	371	1 Chevy	Chase La	ke Drive		20815 ase,Maryland
T B E S	20a. Mathod of Disposition	п (перпе	20b. Place of D	isposition (Nam	a of			City or Town, Stata
Section 1	1 ☐ Burial 2 ☑ Cramation 3 [			crematory or of		Apr. 27		
T E T C	4 Donation 5 Other (Speci		Metropo		rematory		Alexandri	la,Virginia
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tre page.	21. Signature of Funaral Service Lice	nsee			Addrass of Facility	ns Funeral	Home, Ti	nc.
70 F 6 G	( Inches)	J. Corli	,	EAA TT		11 II C:	1 C	ing,MD 20901
	23a. Part1. Enter the disaasa, or conshock, or heart failura. List only	nplidations that caused t	ha death. Do not	t enter the mode	of dying, such as	cardiac or raspiratory	arrest,	Approximate Intarval Batwaan
Physician	Shoot, of Heart failule. List only	One chasa on agon and						Onsat and Daath
/Medical	Immediate Cause (Final	Atheroscl	lorotio	Coronar	v Vacquile	r Disease		
Examiner	disaasa or condition resulting in death)		il Disease					
<u> </u>		U	Due to (or as a co	risequence or,				
axecuted in and intransit Examiner		b	Oua to (or as a co	neadurance of):				I
EXB	Sequantially list conditions, if any, leading to immadiata ceuse. Enter Underlying Causa (Disaasa or Injury	U	ua to (or as a cor	risoquarico or).				
certificate be assouted rights by sician and use as the bunal-transit n/Medical Examir	Causa (Disaasa or Injury that initiated avants	c	ua to (or as a cor					
phy is the	rasulting in death) Last	D	ua to (or as a cor	isequanca oi).				
Iding Ise 8		d						
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ne daath cer the attendin ched for use ysician/N	Part II. Other significant conditions	contributing to death but	not rasulting in the	ha undarlying ce	ousa givan in Part I.			tributa to the cause of dea
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	Physicia /Medic			Cecile	T. Ch	aplin			April	-		5:30 pm
	Examin	_	4a Facility Name (If not institution, give					4b. City, Town, or		4c. County		
		п	3104 Adden	lev Court	# 24	6C		Silver Si	oring	Mon	ntgome	rv
	Funeral		5. Social Security Number 6. Se	9x 7. Ag	e (In yrs. le		der 1 Year	if Under 24 Hrs	8. Date of Birth			ce (Stete or Foreign
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	Jaeth Tre 2	era	11. Marital Status	12. Wes Decedent	Ever in U.S	. 13. Wes D	ecedent of	Hispanic Orlgin? (S ben, Mexicen, Puer	pecify Yes or No-		ed St e - Americar	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hydiano. Department of Health and Mental Hydiano. Important: If them 27 is marked other than "patural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Yeer or Dates:			specify Cui		io Rican, etc.)	Specify	ck, White, etc /: Whi	
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	e da	/sic	Part II. Other significant conditions co	entributing to death b	ut not result	ting in the underlyi	ng cause g	iven in Pert i.	23b. Did to	obacco use co	ntribute to t	he cause of death?
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 14947 Certificate of Death Amend #1,4/28/2000, BMW, Montg.Co. Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Yeer **Physician GEORGIA** CHRISTIAN EORGIA CHRISTIAN APRIL 13:21 24, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospita Johns Baltimore Hop kins City 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 73 Yrs. 223-40-0356 Director Sep 14, VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 28a-f Prince William Manassas 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Nems 23s 10700 Crestwood Drive Apt. 202 20109 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 11. Marital Status e filed within 72 hours after of al Hygiene. other than "natural", or itsm vent, the Medical Examiner. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Home Maker Home permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg. Important: If then 27 is marked other any Injury or other trauments. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 George Moore Amanda Thornton 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Paul M. Moore 119 Rebecca Drive, Winchester, VA 22602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Apr 28 20c. Location - City or Town, Stete 1 St Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Pleasant Bapt Ch Cem 2000 Gainesville, VA 22. Name and Address of Fecility Ames Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 8914 Quarry Road Manassas, VA 20110 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical BILIARY SEPSIS DAYS Examiner Due to (or as e consequence of): Examiner MONTH AMPULLARY MASS attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown RENAL END STAGE DISEASE, HYPERTENSION Records, þ 24b. Were eutopsy findings available prior to 24a. Was en eutopsy performed? Completed LONER GASTROINTESTINAL DISEASE, completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate TRACT BLEEDING Division of Vitai 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospitel: 155 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process. 5 ☐ Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

Registrar

Medical

State

29a. Certifier (Check only one)

SRINIVAS

29b. Signature and little of partition

31. Dete filed (Month, Day, Year)

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PRASAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.

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SURGICAL

HOUSE OFFICER

MD .

32. Registrar's Signeture

Denewas.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

WOLFE STREET,

29c. License number

RES - 000

29d. Date signed (Month, Dey, Year)

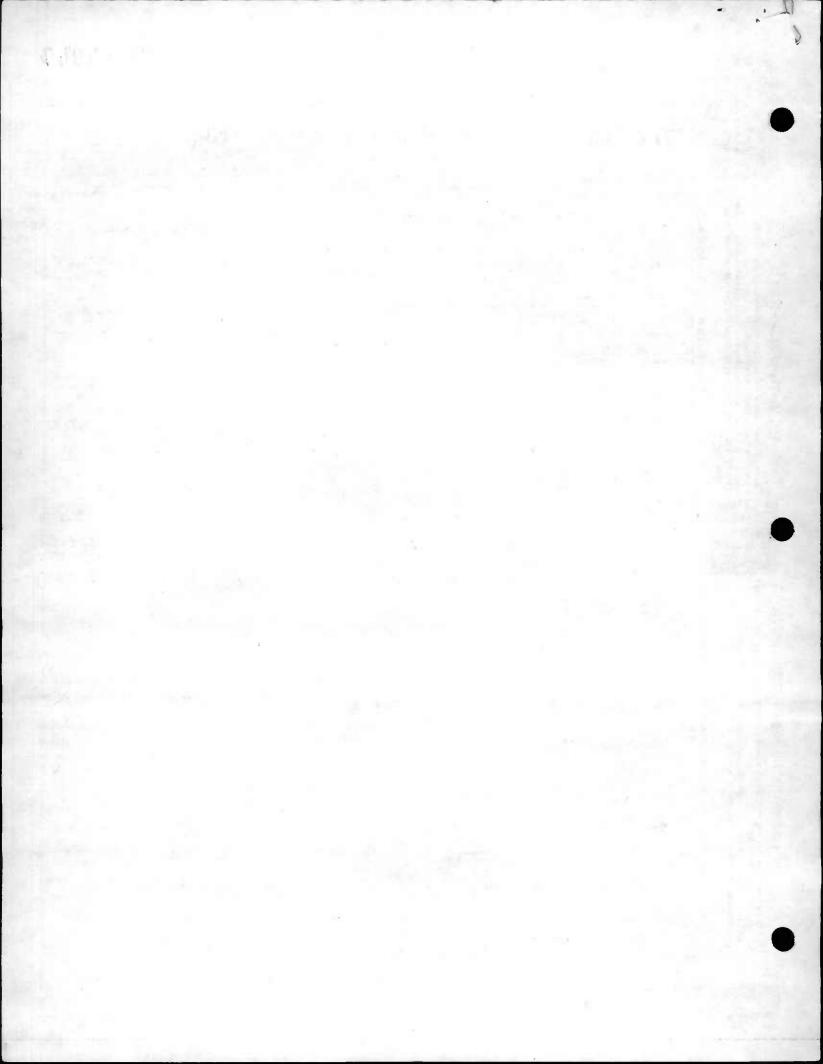
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Certification:	27. Manner of Death 1 ☑ Naturel 5 ☐ Pend	28e. Dete of (Month)	Injury 28b	. Time of Injury	28c. Inju Wo	ry et rk?	28d. Describe I	now injury occur	red	
atic		tigation			M 1	Yes 2 □ No				
F	3 Sulcide 6 Coul 4 Homicide dete	mined   286. Place	of Injury - At home,	farm, stree	et, factory, office		28f. Location (S City or Tox		er or Rurel Route	Number,
e L	4   Homicide	bullain	g, etc. (Specify)				City Of 101	wii, Stelej		
	29a, Certifier 1 Cartifo	ing Physician: To the b	set of my knowledge	ne deeth	occurred at the ti	me date and place	end due to the	reuse(s) and ma	onner es steted	
edicai	(Check only 2 Medica	I Examiner: On the bas	sis of examinetion e							use(s)
Medical Certification: To Be Com	one)	end menn	er Steted.		00-11			and Data day	d Alasti P. V	20.51
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	) ful.									
	1 Jul.	n who completed serves	of death /ltom an-	A CTune D	Print\			7		
	30. Name and address of person					- ATT 11-	Ole To	myraca A	ID 0003	_
	1 Jul.	MUSHER, 1	of deeth (Item 23e M.D. 55 gistrer's Signature		Print) WISCONSI	N AVE. #1	045, BE	THESDA,	MD.2081	5

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND#24A VRBL. RSPNS. PER HSP. G784 6-23-2000 JACertificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** 2000 9:30 AM Jenn 00 APRIL /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** St. Marys Mary 1+03 p. or heuna -d town If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Deys 1 M 2 □ F Yrs. Director 1 18 3. N/A April 2000 Maryland Usual Residence of Decedent death with the Maryland 10a. Stete ahow 10b. County 10c. City. Town or Location 10d. fnside City Limits notified at 1 ☐ Yes 2 @ No Funeral Director 28a-1 Marvland St. Mary's Lexington Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9 the Medical Examiner must be 238 21884 Ronald Drive 20653 United States 14. Race - American Indian, Black, White, etc. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ₹ Never Merried 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v
Department of Health and Mental Hygies
important: if item 27 is marked other th
any Injury or other traumatic event, the
page. N/A N/A N/A Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Daniel Carter, Jr. Yevette Marie Campbell-Waul 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) John Daniel Carter, Jr./Father 21884 Ronald Drive, Lexington Park, MD 20653 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Peter Claver 4-7-00 Ridge, Maryland 21. Signature of Fundial Service Libe 22. Name end Address of Fecility RIZ NO 1114 22955 Hollywood Road, Leonardtown, MD 20650-0279 complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximete Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner to (or es e consequence of) Physician/Medical Examiner The lew requires that the death certificate be executed buriai-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): MICHAEL CARTER of Vital Records, P.O. Box 68760, physicien Due to (or es a consequence of): to Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uea contributa to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy page 2 s XX No 1 ☐ Yes 20 No 1 ☐ Yes certificate Attending Physician: filled in by the funeral director, Be 25. Wes case referred to medicef 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this DEVIN LEO N 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. fnjury et Work? 28d. Describe how injury occurred 28b. Tima of 5 Pending Investigation Naturel Injury death. 1 ☐ Yes 2 ☐ No Hospital or Attendi
 24 hours after death
 Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and menner steted. edicai 29a. Certifier completely within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number 30. Name end eddress of person who completed dause of deeth (Item 23e) (Type, Print) LAWRENCE TILLEY M.D. 23000 MOAKLEY STREET LEONARDTOWN, MD. 20650 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar **10** 2000

Die it was finner to speaking

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14950 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Dey **Physician** Robert Edwin Dauenhauer 26 April 2:00 pm /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2913 Calverton Boulevard Silver Si Spring Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** Months Days Hours 1 € M 2 □ F Yrs. Director 224-22-6674 76 Oct 2. PA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits x 28a-f show 1 ☐ Yes 2 TNo Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3 rms 23a 20904 2913 Calverton Boulevard USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if leen 27 is marked other than "natural", or flems 23s any injury or giber traumatic event, the Madical Examiner must applies. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 € Yes 2 □ No.
1 Yes, Give Feb 43Year or Detes: Mar 46 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: White 2 Specify: 3 Widowed 4 Divorced Mar 46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Buyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Ellsworth Dauenhauer Pearl Sode 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert D. Dauenhauer/son 4204 Alfalfa Terrace, Olney, MD 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 05/01/00 Rockville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, in heart failure. List only one cause on each line. Approximete Intervat Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Goodpastures Syndrome Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificeta be executed anding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760. Due to (or es e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3€Probably 4 Unknown Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? pege 2 should Be Completed 24a. Was an autopsy certificate 1 Yes 2X No 1 Yes 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 \$\overline{\text{Nesidence}}\$ Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending Investigation 1 Natural efter deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tille it certifis 29c. License number 29d. Date signed (Month, Dey, Year) 6 D25914 VA. April 27, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12201 Plum Orchard Drive Silver Spring, Maryland Allen J. Brimmer, M.D., 20904

**DHMH 16 Rev 6/95** 

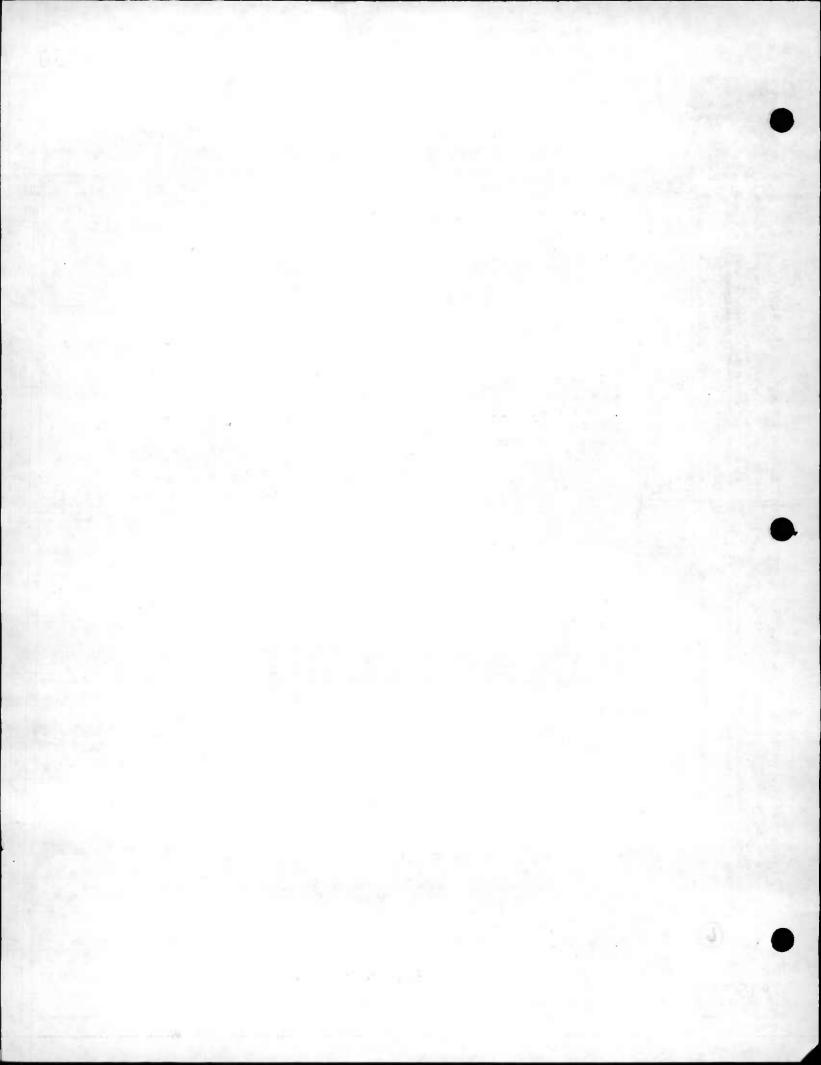
State

Registrar

31. Date filed (Month, Dey, Year)

APR 28 2000

32. Registrar's Signature



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	Examiner	4a Facility Nama	If not institution, giv	a street and numb	er)			T	4b. City, Town,	or Location of Dea		ity of Deat	
		438 GIRA	RD STREE	ET, #101					GAITHER	SBURG	MON	TGOME	ERY
	Funeral Director	5. Social Security I 212-68-7		Aga (In yrs. 47	ga (In yrs. last birthday) If Undar 1 Ya.  47 Yrs. Months Day			rs Hours Min. (Month, D		Sirth Day, Year) 6, 1953	orth ay, Year)  9. Birthpleca (Stata or For Country)  Maryland		
	9	Usual Residence of Decedant											
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2121	ed within 72 hor ygiene. or than "natura it, or Medcall Completed	Elemantery/Sec 12	(Specify only highast grada complated)  Elemantery/Secondary (0-12)  12  Collega (1-4or state of the complated)				DO NOT us	sa retire	during most of the deliberation of the deliber	vorking	Build Maint	0	e
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7	should be and Mente of urmetic of To F	-	19e. Informant's Name/Ratationship (Type, Print)  19b. Mailting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, 2										
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Baltimore,	ment of lury or I I II		☑Cramation 3 ☐ 5 ☐ Othar (Specif		comptany cramatory or other place)							9	
Ball	pemit. Peges 1 and 2 Department of Health Important: if item 27 it any injury or other tre pncs.	MA	unaral/Sarvice Los	M M	100689		Rockvi	ille cvil	lle, Mar	300 West vland 20	Montgo: 850-280	mery	neral Home, Avenue,
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	/Medical	Immediata Causa disaasa or condition	on			DRC	DWNING						
	Examiner	rasulting in death)		8.	Due to (c	or es e con:	sequance of):						N GIN
,0,	physicien end s the buriel-transit	Sequentially list co if any, leeding to it cause. Enter Und	nmediata arlving	b									
68760,	physicies the bur	Cause (Disaasa of that initiated avent resulting in death)	s	c	Due to (or as e consequenca of):								

To the Hospital or Attending Physician: The lew requires that the death carti within 24 hours after death.

within 24 hours after death.

To the Furneral Director: After this certificata has been signed by the attanding complately filled in by the funeral director, paga 2 should be detached for use a Medical Certification: To Be Completed by Physician/M

Division of Vital Records, P.O. Box

Pert It. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part I.

23b. Did tobacco usa	contribute to the cause of death?
1 □ Yes 2 X N	o 3 Probably 4 Unknown
24a. Was an autopsy performed?	24b. Ware eutopsy findings eveilable prior to completion of cause

Yas 2 No

		74 163 2 110										
25. Was casa raferred to medical	26. Placa of Daath (Check only ona)											
axaminar? 1 🎇 Yas 2 🗆 No	Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	ma 5XXRasidance 6 □Othar (										
27. Manner of Death  1 Naturet 5 Pending invastigatio	(Month, Day Year) tnjury Work?	28d. Dascribe how injury occurred SUBJECT DR										

FOUND: FOUND: 6 Could not be determined 3 ☐ Suicida 4 ☐ Homicide Plece of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

ECT DROWNED 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 438 GIRARD ST.APT 101 GAITHERSBURG, MD

6 ☐Othar (Specify)

RESIDENCE 29a. Certifier (Check only one)

1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the causa(s) and mannar es stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. Licansa number 29d. Data signad (Month, Day, Year)

29b. Signatura and titta of pertifiar

APRIL 21,2000 O.C.M.E.

complated causa of death (Itam 23a) (Type, Print)  $V_5$ ,  $N_t D$ . 111 30. Nema and addrass of person who

2000

31. Date filed (Month, Day, Year)

APR 25

111 Penn Street, Baltimore, Maryland 21201

State Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Nerge (First, Middle, Last) Day Month Year Tohammed 2000 04 4c. County of Death 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Regional Prince George's aurel Hospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) India 5. Social Security Number 7. Age (In yrs. last birthday) Deys 15M 20 F 213-78-2099 92 Vrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Laurel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Hunting Lane, #104 20708 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 Tho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tax Collector State of Madras 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Hussain Ali Sayeed Khatija 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Khudsia B. Dost (wife) same as #10 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1√2 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Md National Memorial Park 4/27/2000 Laurel, Maryland at Funeral Service Light Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or con shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, one cause on each line. Immediate Ceuse (Finel disease or condition resulting in death) Dhe hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): that initiated events resulting in death) Lest Due to (or as a consequence of) Part II. Other alignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown anem19 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy normania 1 ☐ Yes 2 ☐ No 1 Yes 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be determined

The law requires that the death certificete be executed use es the burial-transit ettending physician and for use es the burial-tran Division of Vital Records, P.O. Box 68760, been signed by the should be detached page 2 should hes this certificete : After this certifice e funeral director, p f or Attending Physician: efter death. Director: After this certifice illed In by To the Hospital of within 24 hours e To the Funeral D

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

**Funeral** 

**Director** 

Hem 27 is marked other than "natural", or frems 23s or 28s-1 show other traumatic event, Its Medical Examinar mess to mother traumatic event,

permit. Peges 1 and 2 should be filed within 72 hours efter death be Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any injury or other traumetic event, Item Medical Examinations.

**Physician** /Medical

Examiner

Physician/Medical Examiner

2

Completed

Be

2

Certification:

edicai

the Meryland

25. Wes cese referred to medical examiner? 1 Yes 2 No 27. Menner of Death Dature!

4 Homicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

dertifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature Ad title of certifie

29c. License number

29d. Date signed (Mgnth, Day/Year)

who completed cause of death (Item 23a) (Type, Print) eddress of persog

1395 JOHN Margolis

31. Date filed (Month, Day, Year) APR 28 2000 32. Registrer's Signature

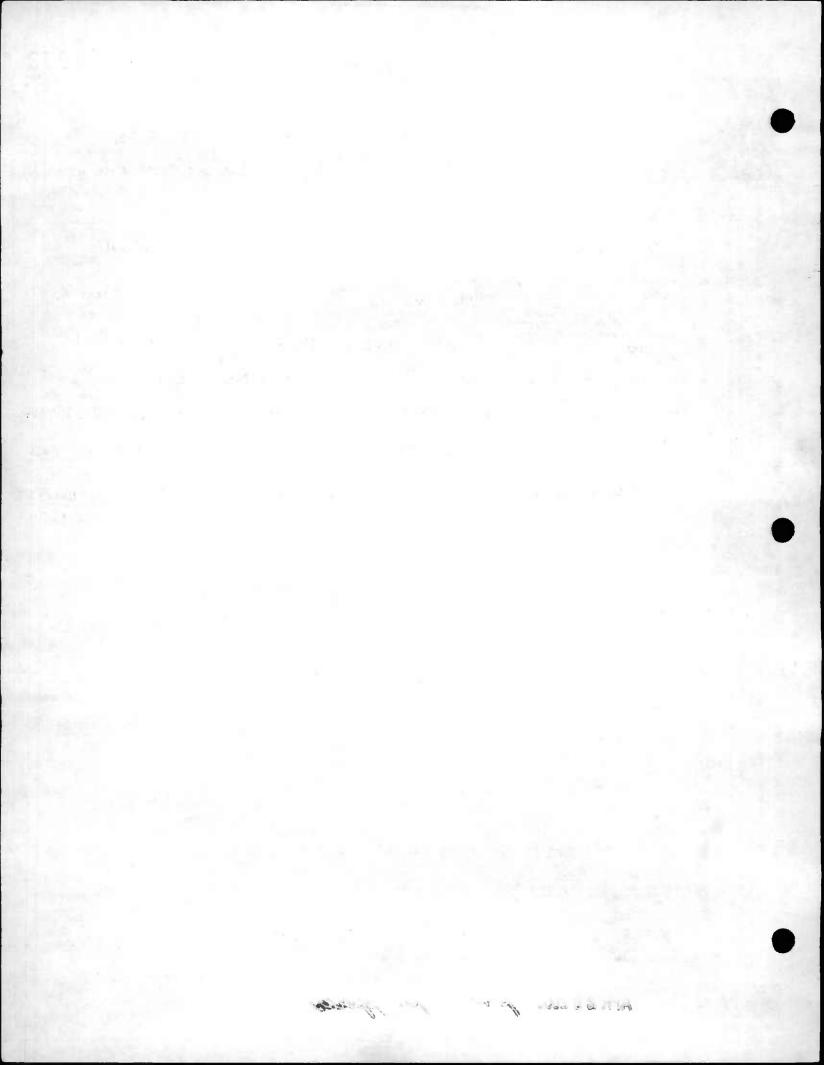
Registrar

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Proceed II loure

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of Death	,	Reg. No.	0 14953
	Dhusisian	1. Decedent's Nama (First, Middle, Last)	0			2. Data of Dea Month /	ath Day	3. Time of Death
ą.	Physician /Medical	1.4 000	PYS	on		April	~ ~	000 3:21 AM
	Examiner	An English Mann of and institution when	street and number)	1	4b. City, Town, or	Location of Death		
		University of Narry	land Medical	3ystems	er 1 Year   If Under 24 Hr	one	C,	~
	Funeral Director	5. Social Security Number  3.32-30-4554  Usual Residence of Decedent	7. Age (In yrs.	- Month:		. (Month, Da)	V. Year) 8)934	9. Birthplaca (State or Foreign Country)  Maryland
	B ==	10a. Stata 10b. County	10c. Ci	ty, Town or Location				10d. Insida City Limits
	or 28s-f ships to retired a	MD Hart	ord		de Grace		10g. Citizen of W	1 □Yas 2 □ No
1	after dean with the wayner or flems 23a or 28a-f show imfrar must be rotified at V. Funeral Director				21018		U	SA
020		3 DWidowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 (2) Yas 2 □ No If Yes, Give Yaar or Datas: 1950	4□Vaa	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yas of No- rto Rican, atc.)	Specify:	a - Amarican Indian, k, Whita, atc.
5-0	"netural",	15. Decedent's Educ (Specify only highest grade	cation	16a. Decedent's Us	uat Occupation	orking	16b. Kind of Bus	siness/Industry
21215-0020	than the	Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during most of wouse retired)  INS TECH.		HO	soital
Pu	E 1 8 8	17. Father's Nama (First, Middle, Last)				ıma (First, Middle,		a)
yla	and Mental la marked or aumatic ave	James K. WI	130n, Sr.		Et	ella	E117	
Maryland	Pra a	19a. Informant's Name/Ralationship (Ty)			ss (Street and Number or F			
	f Health fam 27 other tr	Harry L. Dyson, J						e mid 21078
Baltimore,	10 10	20a. Method of Disposition  1  Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emovel from State	Place of Disposition (No cometery, crematory or L. Junes	other place)	4-18-90		e Grace, MD
Balt	Department Important: I any Injury o	21. Signature of Funaral Service License		22. Nama	and Address of Facility	EE FUI	neral s	
E	Medical Examiner	Immediata Cause (Final disease or condition resulting in death)	Cerebellar Due to (c	- hemakenya or as a consequence of	):			
68760,	reat the present certificate be expected ed by the attending physician and detached for use as the buriel-trensit y Physician/Medical Examiner			or as a consequence of				
Box 68	attending physicis						16.554	
m ;	o atte	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause given in Part I.	23b. Dld t	obacco use con	tribute to the cause of death?
P.0	igned by the attend be detached for us. by Physician/	GI bleed.			101	./	3 ☐ Probably 4 ☐ Unknown	
of Vitai Records,	s been a 2 should	GI bleed.  Hydroeplulus				24a. Was a perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
E .						1)00	as 2□No	1 ☐ Yas 2 ☐ No
/ita	cartificets rector, page 3	25. Was case referred to medical axaminer?				eath (Check only o	ne)	
of Vita	E E	1 ☐ Yes 2 ☐ No		ER/Outpatient 3 [		Homa 5□ Rasid		* * * * * * * * * * * * * * * * * * * *
onois	To the second	27. Manner of Death  1 Natural 5 Pending  2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe h	now injury occurre	ed .
5	1 = 5 E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, atc. (Special		ory, office	28f. Location (S City or Tow		er or Rural Route Number,
2	in 24 hours the Funeral pletely filled	29a. Cartifier (Check only one)  Certifying Physical Examination	ician: To the best of my known:  On the basis of axamina and manner stated.	wledge, death occurre tion and/or investigation	d at the time, data and place on, in my opinion, death occ	ce, and dua to tha courred at the time, of	ausa(s) and mar date and place, a	nnar as stated. Ind due to the cause(s)
_ 4	within 2 To the comple	29b. Signature and title of certifier	1/7	2	9c. License number		29d. Date signed	(Month, Day, Year)
		70 Nov. and		MO	712446		April	18 2010
	6	T. Mattingly	impleted cause of death (Iter	the Greene =	street Baltin	ione Ma	ryland	21201
	State	31. Date filed (Month, Day, Year) APR 2 0 200	32. Registrar's Signa	ature &	south			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death 10:15 Year Month **Physician** avis, 24 4b. City, Town, or Location of Death James 2000 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner mount Airy Home Nursing JarroLL Pleasant VIEW | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Sept. 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1MM 2□ F Yrs. 1914 Kentucky Director <u>365-01-4187</u> Usual Residence of Decedent 10a. Stete 10c. City, Town or Location e filed within 72 hours after death with the Marylan al Hygiene.
other than "naturat", or items 23a or 28a-1 show vent, the Medical Examinat must be netitled at 10d. Inside City Limits 1 Yes 2 □ No MD Carrol1 Mt. Airy Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17756 Hardy Road 21771 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied v
Departmant of Health and Mental Hygies
Important: If Item 27 is marked other th
eny Injury or other treumatic event, that
once. 12 0 Sales Manager Automobile 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be David O. Davis Josephine Hamline 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) James S. Davis, Jr./Son 17756 Hardy Road Mt.Airy, MD 21771 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 X Buriel 2 ☐ Cremetion 3 ☐ Removet from State 4/28/2000 Marriottsville, MD Crest Lawn Memorial Gardens 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Fecility Jeffrey N. Zumbrun Funeral Home 21. Signature of Funeral Bervice Licensee combrun 6028 Sykesville Road Eldersburg, Maryland 21784 23a. I art1. Emer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner attending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown rosa þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peeu Jas 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this 27. Menner of Deeth 1 Natural 28e. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending Investigation 1 Yas 2 No 2 Accidant 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Pleca of fnjury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred et tha time, data and place, and dua to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, end dua to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29b. Signature and sittle of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar **DHMH 16 Rev 6/95** 

State

mī.

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

2000

OR Ronald Emiller

APR 26

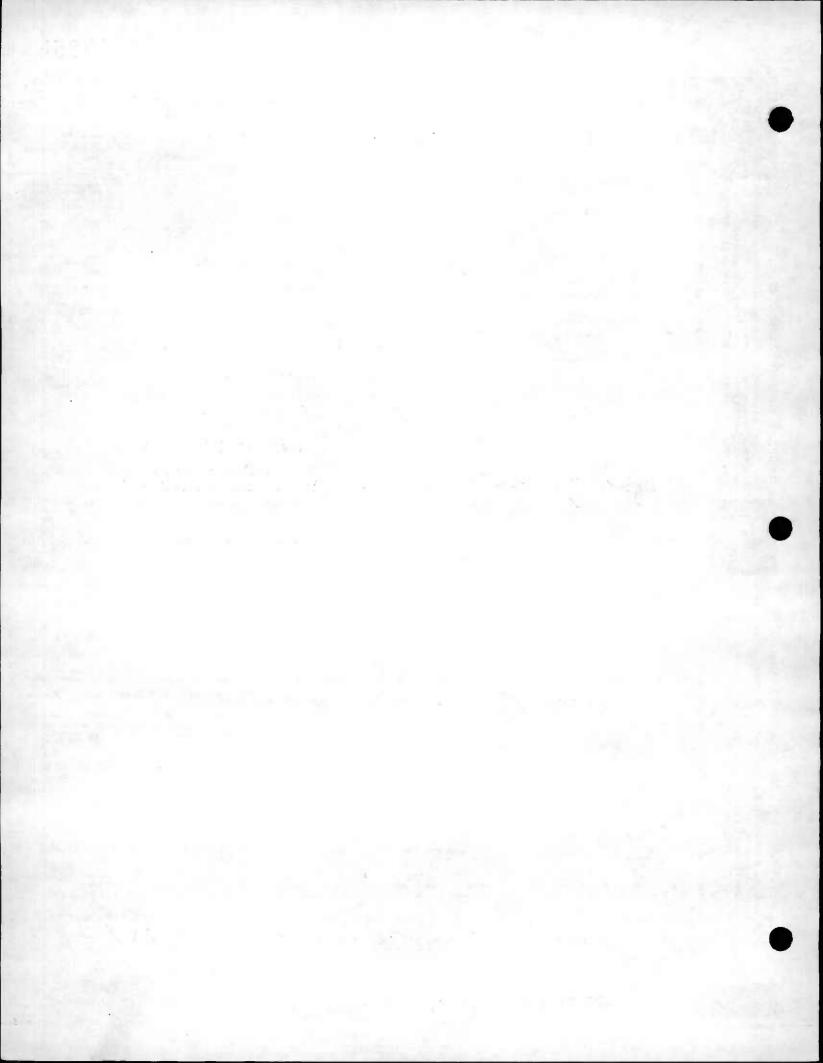
31. Dete filed (Month, Dey, Year)

P.O. Box 210

32. Registrar's Signeture

00

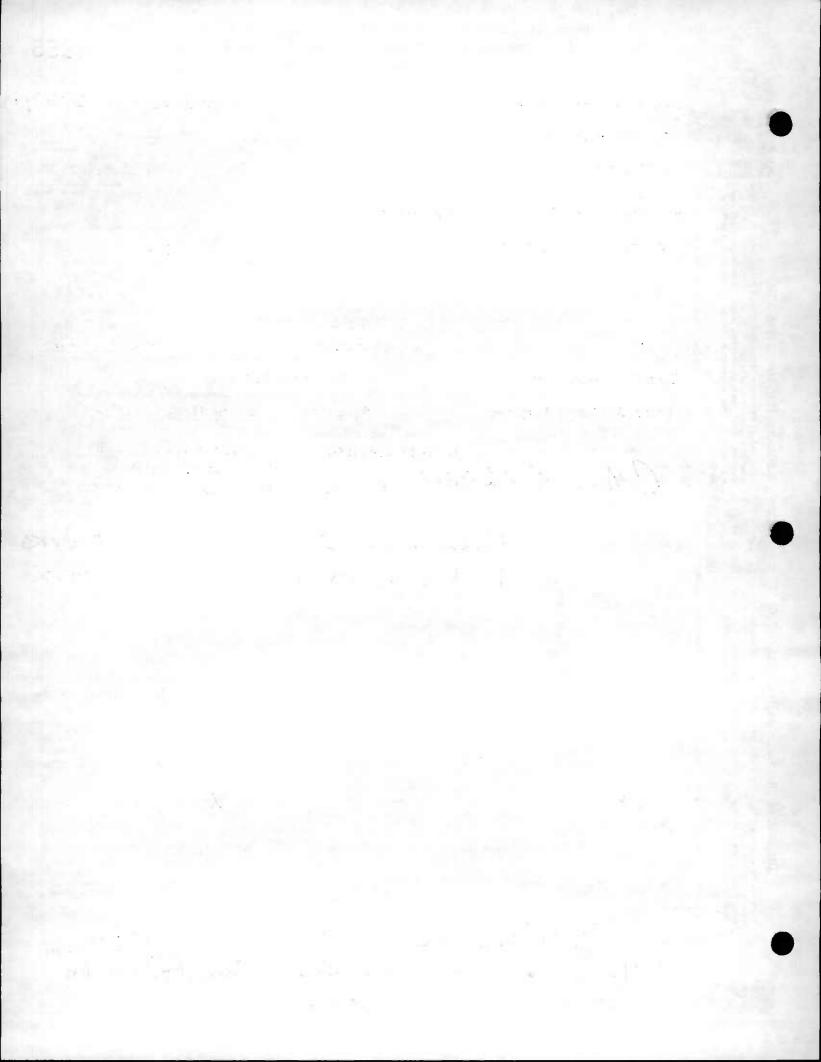
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State of Maryland / Department of Health and Mental Hygiene 00 14955

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	1. Decedent's Nar	ne (First, Middle, L	est)							2. Date of De		Year	3. Time of Death			
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miner		(If not Institution, gi					4	4b. City, To	wn, or Lo	cation of Deat						
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ral	5. Social Security	Number 6.	Sex	7. Age (In yrs.	last birthday,		ler 1 Year	Taney		8. Date of Bir	th		lace (Stete or Foreign			
or	212-32-23	300	1∭M 2□F	70	Yrs.	Month	s Days	Hours	Min.	(Month, Da	2, 1929	Mary	ny) Tand			
-	Usual Residence												20114			
	10a. State	10b. County		10c. Ci	ty, Town or L	ocation						1	0d. Inside City Limits			
to	Maryland	Carrol1		Ta	neytow	'n							1 ☐ Yes 2 🖾 No			
Director	10e. Street and Nu	umber		- 11-		10f. 2	Zip Code				10g. Citizen of	What Coun	try?			
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Funeral	11. Marital Status	cerdare ii	12. Was Dec	edent Ever in U	J,S. 13.			lispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		ca - Americ				
E	1 Never Mar	ried 2 Married	Armed Fo	20 No					, Puerto	Hican, etc.)	Bla	ck, White,	etc.			
by	3 XWidowed	4 Divorced	If Yes, Gi Year or D	de ates:		1 ∐ Yes	2 No	Specify:			Speci	y: Whit	0			
Completed		15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occup	ation			16b. Kind of E					
ple	(Spe	ecify only highest gr		4	(Give	kind of v DO NOT	vork done o use retired	during most	of worki	ing						
E	11	condary (0-12)	College (	1-401 5+)	Bus C	ontr	actor				Board	of Ed	ucation			
C	17. Father's Name	(First, Middle, Las	t)		1000	Onci	accor		r's Name	e (First, Middle	, Meiden Sume		ocation			
o Be	Edward I	J Dorr	C.					M	. M 1	14000						
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											lle, MD					
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	20a. Method of Dis	Cremation 3	☐Removal from	State	Placa of Disp cemetery, cre	matory o	r other plac	ce)	1	Date	200. Location	- City of To	WII, State			
		5 Other (Speci			roll (	Crema	ation	. Inc	. 4	$\frac{1}{24}$	Hampste	ad. M	ld.			
	4 Donation 5 Other (Specify) Carroll Cremation, Inc. 4/24/00 Hampstead, Md.  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home															
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	23a. Part1. Enter	the disease, or con art failure. List only	nplications that	aused the dea								Land .	Approximate			
	shock, or he	art failure. List only	one cause on (	each line.									Interval Between Onset and Death			
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Physicia	Part II. Other signi	ificent conditions	contributing to d	eath but not res	sulting in the	underlying	g cause giv	en in Part I		23b. Did	tobacco usa c	ontribute to	the cause of death?			
Ph										1	Yes 2 No	3 🗌 Pro	bably 4 Unknow			
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P										24a. Was	s an autopsy ormed?	av	ere autopsy findings ailable prior to			
P										· ·		co	mpletion of cause death?			
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à	27		1 □ Yes 2 No													
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To Be Completed by	examiner? 1  Yes 28 27. Manner of Dee	No oth 5 ☐ Pending	28a. Date (Mon	Inpatient 2 Cofficient of Injury th, Day Year)	ER/Outpatie	of	28c. Injur Wor	y at		/\_		rred				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** LILA DORIS DAYMUDE APRIL 2000 5:20 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND If Under 24 Hrs. 8 MEMORIAL HOSPITAL & MEDICAL CENTER ALLEGANY If Under 1 Year Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaar) **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. Director Sept. 24, 1914 232-24-1132 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location IOd. Inside City Limits A Haith and Mentel Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1⊈ Yes 2 No Director Maryland
10e. Street and Number Grantsville Garrett 10f. Zip Code 10g, Citizen of What Country? 21 N. Pennsylvania Avenue, Apt. 100 21536 Funeral USA 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Giva 1 ☐ Nevar Married 2 ☐ Married aitimore, Maryland 21215-0020 1□ Yes 2 No Specify: Specify: þ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Clerk Pharmacy permit. Pagas 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 (Unknown) Stone (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Margie Menges/Friend 4246 National Pike, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Grantsville Cem., April 29, 2000 Grantsville, MD 21. Signature of Funeral Service Licensea 22. Nama and Address of Facility Newman Funeral Homes, P.A., 179 Miller Street lusa P.O. Box 275, Grantsville, MD 21536 23a. Part1. Entar the disasks, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hailure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediate Causa (Final disease or condition resulting in death) a ACUTE MYOCARDIAL INFARCTION HOURS Examiner Due to (or as a consaquence of): CORONARY HEART DISEASE YEARS burial-transit Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequance of): and physician s the burial Box 68760 DIABETES MELLITUS YEARS an/Medical Dua to (or as a consequence of): 88 USB ò Physici ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown LEFT ABOVE THE KNEE AMPUTATION, CHRONIC OBSTRUCTIVE Records. by 24b. Were autopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy performed? pluods Completed Deen PULMONARY DISEASE, HYPERTENSION, BREAST CANCER Division of Vitai 25. Was casa ratarrad to medicel examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2[
28a. Date of Injury (Month, Day Year) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Othar (Spacify) 10 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death funaral 28b. Time of 28c. tnjury at Work? 28d. Dascribe how injury occurred Certification: at or Attain.

us after death.

eral Director: Aftr
hu tha fu Aftar Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Dicomplately tilled in 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the contribute 29c. License number 29d. Data signad (Month, Day, Year) D 0054411 APRIL 27, 2000 30. Name and address of person who complated causa of death (Hern 23a) (Type, Print) 3 Beverly Calkins, M.D., 500 Memorial Avenue, Cumberland, MD

**DHMH 16 Rev 6/95** 

State

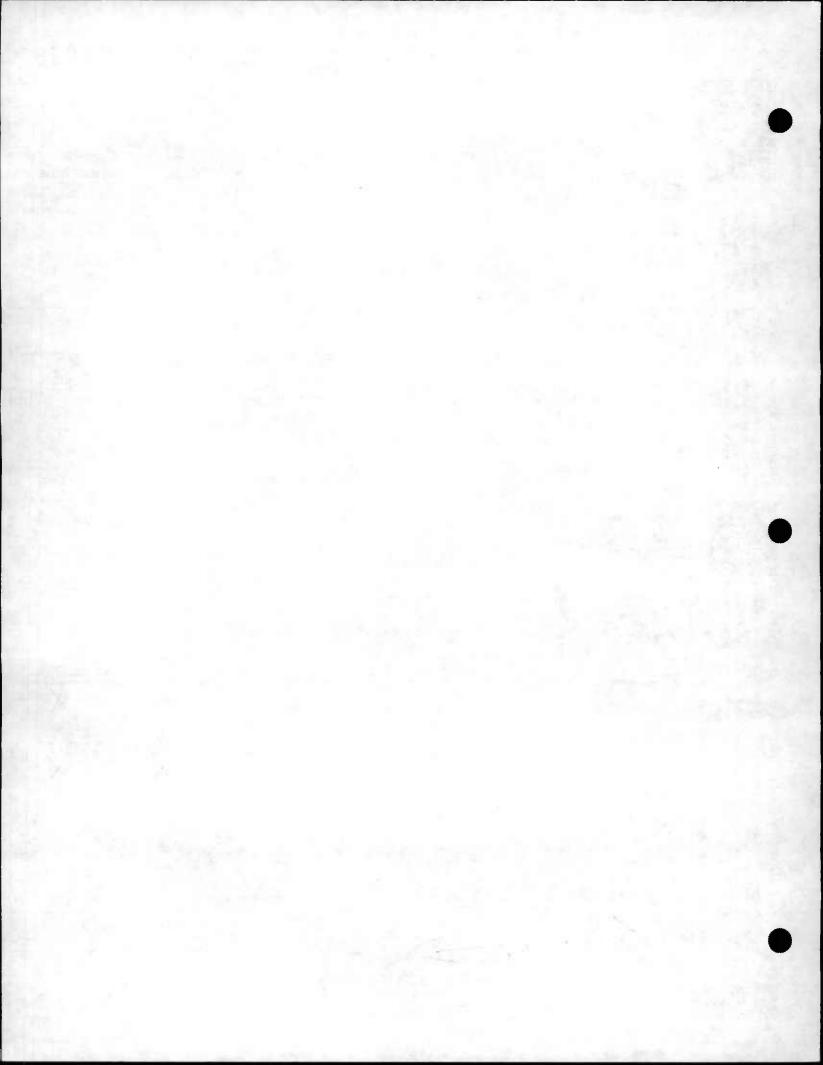
Registrar

APR 2 8

2000

31. Data filed (Month

32. Registrar's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 14957

						Cer	tificate of	Death		Reg. No.					
	Discolate		1. Decedent's Name (First, Middle, I	ast)					2. Dete of De Month			3. Time of Deeth			
	Physicia /Medic		REGINA DELORES	DOBRY					APRIL	L 24, 2000		12:05 PM			
4	Examin		4a Fecility Name (If not institution, g					4b. City, Town, o	or Location of Deat						
			GARRETT COUNTY				Mile Is a Mar	OAKLAN	_		RETT				
	Funeral Director		215-52-2069	Sex 7. Ag 1 ☐ M 2 🖾 F	ge (In yrs. I	ast birthday) Yrs.	Months Deys			nth (1910), Year)	9. Birthp Coun MAR	lace (State or Foreign try) Y LAND			
and	<b>≥</b> 220	-	Usual Residence of Decedent  10e. State 10b. County		10c. City	, Town or Loc	cation				1	0d. Inside City Limits			
Mery	# B	ō	MD BALTIMO	RF	MC	NKTON					1X Yes 2□No				
the the	1288 Inoth	Tec.	10e. Street end Number		110		10f. Zip Code			10g. Citizen of What Country?					
with	98		1036 CORBETT RO	AD			21	111		USA					
deat	E B	Funeral Director	11. Marital Stetus	12. Wes Decadent Armed Forces	Ever in U,	S. 13. V	. 13. Was Decedent of Hispenic Origin? (		(Specify Yes or Netro Rican, etc.)	o- 14. Race Blec	- Americ	an Indien, etc.			
Z1Z15-00Z0 d within 72 hours after death with the Mervland	si', or it	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No If Yes. Give 1 ☐ Yes			Specify:			WHI				
2-C	alon dien	Completed	15. Decedent's (Specify only highest of	Education trade completed)		16a. Deced	ent's Usual Occu	petion during most of ( ed)	working	16b. Kind of Bu	siness/Ind	dustry			
Z ig	P P P	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retire MEMAKER	9d)		OUN	HOMI	7			
N Sel	ntal Hygier ed other th	ပိ	17. Father's Neme (First, Middle, La	et)		пс	MEMAKEK	18 Mother's N	lame (First, Middle			<u> </u>			
and		To Be	JOSEPH	WYSC	CKT			ANNA	(		- nknov	m			
Nous A	nark mark	ř	19a. Informant's Name/Relationship		a Address (Stree		Rural Route Numi								
Maryland Id 2 should be file	ith ar 27 ie trau	1	REGINA SIMPKINS			NTERBER			ALLEY, M						
<b>5</b> , - s	tem tem	ŀ	20e. Method of Disposition			lace of Dispos	sition (Name of natory or other pl	eco)	Date	City or To	own, State				
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after beath with the weightst Department of Health and Mental Hydiene. I importanted the TI is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, the Medical Evantinet must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				EMATORY	200)	4/25/00						
		ł	21. Signature of Juneral Service Lic				. Name and Addi	ess of Facility		. BOX 24					
n a	De la la	-	Me JUN	Quet	M0016	67 E	URST FU	NERAL HO	ME - OAK		_	50			
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PI	hysician		Onset end Death												
	/Medical xaminer		disease or condition	a. conge	stiv	re hea	rt fai	lure				5yrs			
E.	Adminici	resulting in death)  Due to (or as e consequenca of):													
P	is is	line		b. acute	and	chro	nic re	nal fa	ilure		1	yrs			
xecut	and Il-tran	edicai Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury cause (Disease or Injury cause)												
, P.O. BOX 68/60, that the death certificate be executed	physician and the bunal-transit	ie	cause. Enter Underlying Cause (Disease or Injury that initiated events	ccompl	c. complicated diabetes mellit					tus type 2					
ficate	g phy: as the		resulting in deeth) Last												
Bath certi	nding use a	2		d											
de de	been signed by the attendir should be deteched for use	Physician/M	Part II. Other significent conditions	contributing to death I	but not resu	ulting in the ur	ndertying cause o	iven in Pert I.	23b. Dio	I tobecco use co	ntribute to	the cause of deeth			
T the C	by th	hys	_ ·	-					10	Yes 2 No	3 ☐ Pro	bably 4 Unknow			
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Ords	pino	ğ								s en eutopsy formed?	av	ere eutopsy findings ailable prior to			
9 8	2 0	Completed							-		of	mpletion of cause deeth?			
= F	page page	Son							1□	Yes 2 No	1 [	∃Yes 2□ No			
Of Vital	certificate rector, pag	Be	25. Wes case referred to medical examiner?	11 - 5 - 7					Death (Check only	one)					
- 5	0 0	2	1 Yes 2 No	Hospital: 1 Inpet		ER/Outpatien	T 3L DOM		g Home 5□ Res	idence 6 Oth		(y)			
on C	After	on	27. Manner of Death  1 Matural 5 □ Pending	28a. Dete of Inj (Month, D	ay Year)	28b. Time of Injury	28c. Inj W M 1[	uryat ork? ]Yes 2∐No	280. Describe	now injury occur	90				
DIVISION or Attending	death tor:	Icat	a Accident Investigat 3 Suicide 6 Could not	be one Place of In	iury - At ho	ome farm stre	eet, factory, office		28f. Location	(Street and Numb	er or Rura	al Route Number.			
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Hospita	within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edicai C		Physician: To the best aminer: On the basis of end menner s	of examinat										
o the	ompl	Me													
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			30. Name end eddress of person wh	o completed cause of	death (Item	1 23e) (Type. I		050		4/24	120	UU			
	3		Margaret Ka					t. High	wav. Oa	kland.	Мд	21550			
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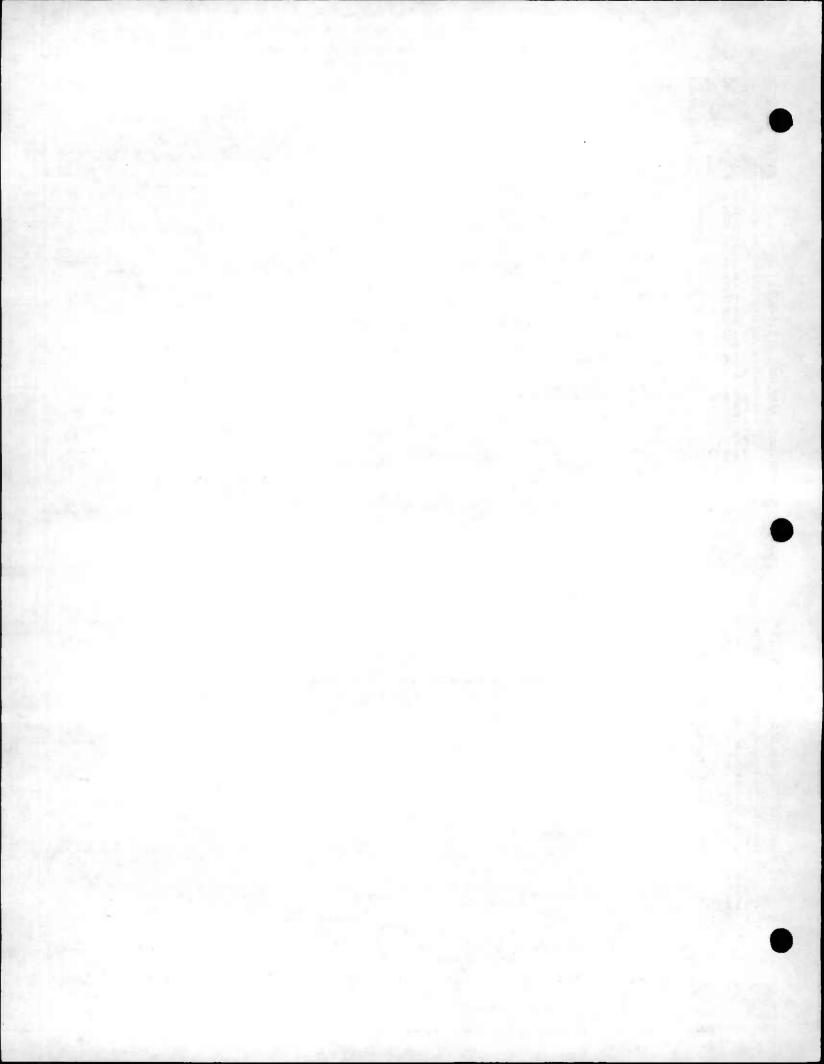
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State of Maryland / Department of Health and Mental Hygiene 0 0

Certificate of Death

						Cei	runcate of	Deam		Reg. No.				
Physicia	n 🗆 🗀		a (First, Middla, L						2. Data of D Month	eath Dey	Yaar	3. Tima of Death		
/Medica	al		John Ed						April 22, 2000 1:23 p					
Examine	r <sup>4a</sup> Fac	ility Nama (h	not institution, g	ive street and nu	mber)			4b. City, Town	i, or Location of Dea	Location of Death 4c. County of Death				
			e Lane					Rockvil		Monts				
Funeral	5. Socia	al Security N	umber 6.	Sex 1☑M 2□F	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days		Hrs. 8. Data of B Min. (Month, D	irth	9. Birth	nplaca (Stata or Foraign untry)		
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7 .		Residence of												
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Me Pa	Mar	yland	Montgo	mery		Rockvil	1e					1⊠Yas 2□No		
with the Maryla a or 28a-f show Libe notified at	Mar 10e. St	reet and Nun	nber	111111			10f. Zip Code			10g. Citizen of	What Cou	untry?		
Sa Cal		Aleac	e Lane				208	51		USA	٨			
er death with the Maryla flerns 23s or 28s-f sho ner must be notified at		rital Status	e name	12. Was Dec	edent Evar in	U,S. 13.			n? (Specify Yas or N Puarto Rican, atc.)					
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within 72 hours after ene. then "netural", or fe he Medical Exemple	-		4 Divorced	M Vac Gi			1□ Yas 2☑ No	Specify:		Specif	y: ,	White		
the sale			15. Decedent's E		KOLE		dent's Usual Occ	ination						
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	23a. P	art1, Entar th	e disease, or cont lailure. List only	nplications that	caused tha da	ath. Do not ent	ar the mode of ch	ring, such as ca	rdiac or raspiratory	arrest,	1	Approximata Intervel Betwaen		
Physician				100000000000000000000000000000000000000							1	Onsat and Daath		
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Examiner	rasultir	g in death)		a. Bladd							- 12	2 years		
	Due to (or as a consequence of):													
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the sky	Cause that init rasulting	g in death) L	ast		Due to	(or as a conseq	juence of):							
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that the death	Part II.	Other signifi	cant conditions	contributing to d	leath but not re	esulting in the u	nderlying causa g	jiven in Pert I.	23b. Die	I tobacco use co	pacco use contribute to the causa of death?			
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signed I									_	1⊠Yee 2∐No 3∏Probably 4[				
he law requires that the death has been signed by the atte	5								24a. Wa	s an autopsy	24b. V	Vera autopsy findings		
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The law ate has b	Q.										0	of death?		
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sician: The certificate lirector, pag	25. Wa		ed to medical			TEMES		26. Placa of	Death (Check only	ona)				
	0 1	minar?  Yas 2⊠	No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	ther: 4 Nursi	ing Homa 5 🖾 Ras	sidence 6 DOtt	nar (Spec	cify)		
7 4 4 7		ner of Death		28a. Dete	of Injury	28b. Time o	1		-	how injury occur		,,		
Attending For death.  Sector: After by the funer	- 1	Natural Accident	5 Pending investigation		nth, Day Year)	Injury		ork? ⊒Yes 2.∐No						
or Attending after death. Director: After din by the fune	3	Suicide	6 ☐ Could not	De Dies	a of loiuny . At	home farm str	eet, factory, offic	a .	281. Location	(Street and Num	ber or Ru	ral Route Number.		
Direct A in by	40	Homicide	detarmine		ing, etc. (Spec		est, lactory, onle		City or To	own, Stete)	20. 0. 1.0.	Territorio riambor,		
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10		T	MILL	0 11	111111	MOM	D 197	785		Apr.24	2000	)		
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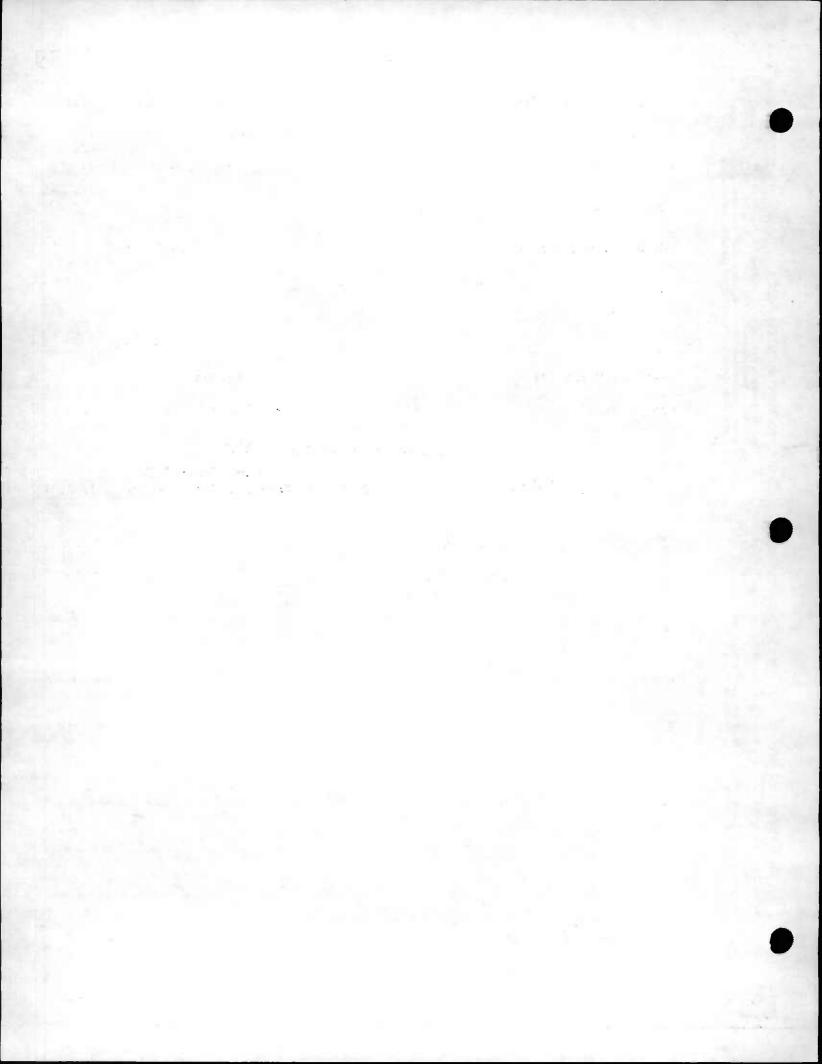
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Daath Month **Physician** Amelia В. Eisel April 24, 2000 10:15am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 Odend Hal Ave. #214 Gaithersburg Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year, **Funeral** Months Devs Hours 1 M 2 VF 79 Yrs. 213-22-4215 June 28, 1920 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow MD. Montgomery Gaithersburg 1X Yes 2 No Director or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 101 Odend Hal Ave. #214 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiena.
other than "natural", or item Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White à 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event pides. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be David M. Holsinger Anna Nelson 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John K. Eisel (Son) 19831 Beatriz Street Poolesville, Md. 20837 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date Apr. 26, Rockville, Md. 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Cardiovascular Disease Years Examiner Due to (or as a consequence of): Physician/Medical Examiner Hypertension Years The lew requires that the death cartificata be axacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last ettanding physician and for use as the bunal-tran Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No signed t þ cate hes been sig. pega 2 should b 24b. Were eutopsy findings available prior to Be Completed 24a. Was an autopsy completion of cause of death? cartificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: "
within 24 hours aftar death.

To the Funeral Director: Aftar this cartifica complataly filled in by the funeral director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1X Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 5 Pending Investigation 1 XNatural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 51936 April 24, 2000 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sally Belcher M.D. 12851 Wisteria Dr. Germantown, Md. 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 2000 Registrar

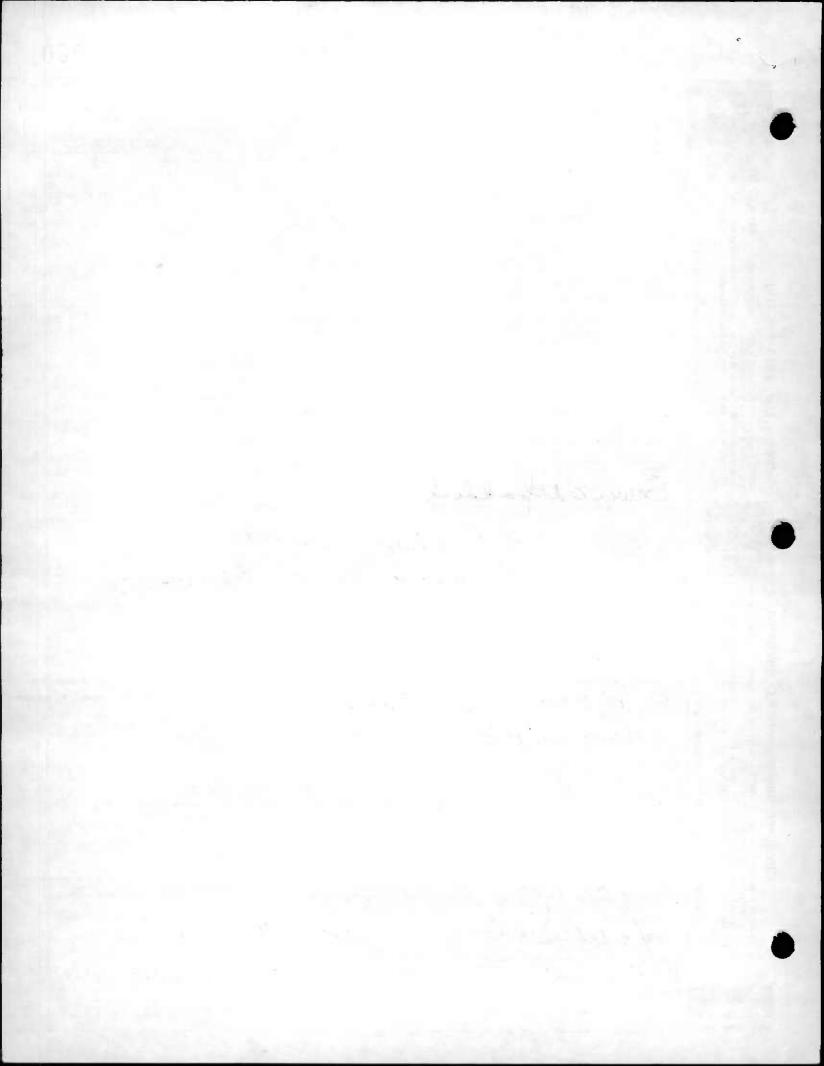
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O Page	T	4 🗆 Homicide	determined		, etc. (Specif					City or Tow	n, State)			
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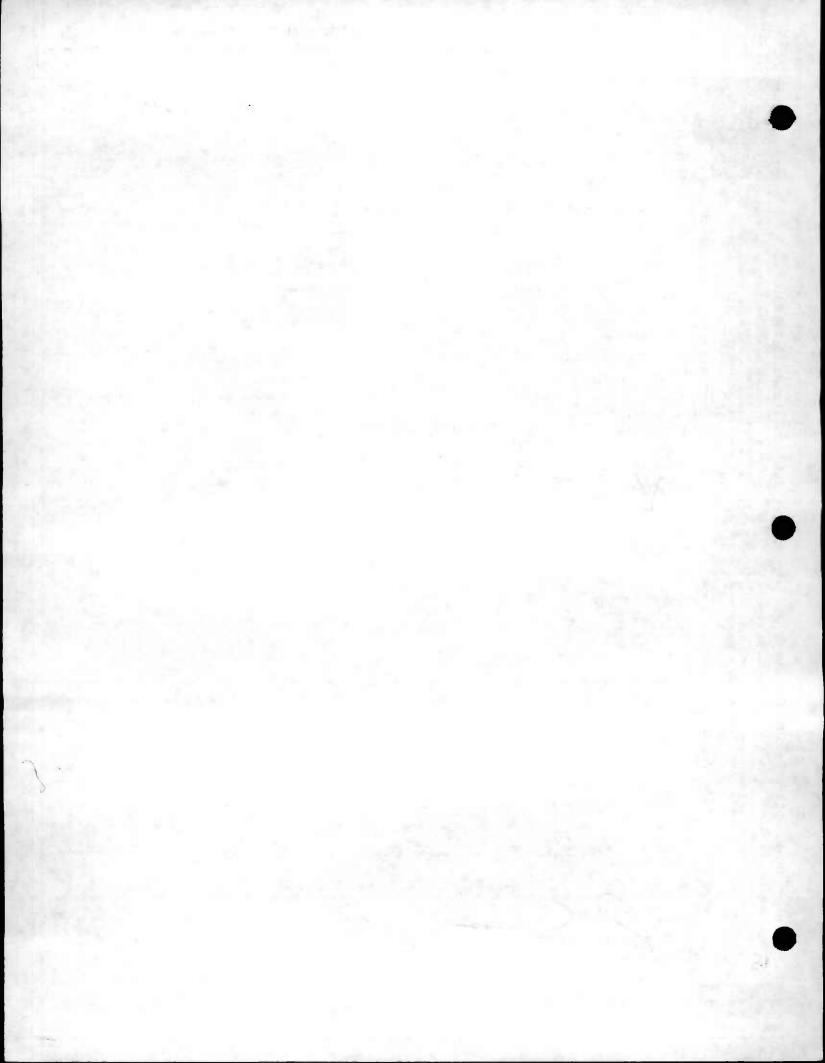
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14961

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Physician	1. Decedent's Nama (First, Middla, La	st)	X 2 5 1 1			2. Data of De Month	ath Dev	3. Tima o	f Death				
/Medical	Cletus Monroe Est				April 21, 2000 8								
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and n 27	Bruce A. Estep/ S		yland 2083:	2									
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Pege Int: If	1 Burial 2 Micramation 3 Ramoval from State 4 Donation 5 Other (Specify)  Apr. 24  Montgomery Crematorium, Inc. 2000 Bethesda, 1												
emit. Peges 1 ar Sepertment of Hea mportant: if item iny Injury or other and ing Injury or other	21. Signature of Funeral Sance Leansee  22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home  Retherda—Chayy, Chara The 7557 Historial Assert												
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15+1	30. Name and eddress of person who	completed cause of daat	th (Itam 23a) (Type	, Print)	1100-	- Indiana							
10	Richard Schoenfeld		30 Wiscon		nue. #930	), Chevv	Chase. N	(D 20815					
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## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4962 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 26, April Milton J. Evans 2000 5:00 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 15124 Watergate Road Silver. Spring If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** Months 1⊠M 2□ F Yrs. 87 Director 471-12-1407 July 24 1912 Minnesota Usuel Rasidence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 28a-f MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ ment b 15124 Watergate Road 20905 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Neable and Mental Hygiene. Important if Neable and Mental Hygiene. any injury or other trausment other in. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 14 Bace - American Indien Bleck, White, etc. 1 Nevar Married 2 Married Specify: White If Yes, Give Year or Detes: 1 ☐ Yes 2 ☑ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Employment Security Federal Government 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Robert H. Evans Ella S. Johnson 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Hallie Tolker / Sister 1918 Carmody Drive, Silver Spring, MD 20902 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method ol Disposition 20c. Location - City or Town, Stata t Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery |5/01/00|Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd W., Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart lailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Atherosclerotic Coronary Artery Disease 7 years Examiner Due to (or es e consequença of): Physician/Medical Examiner The lew requires that the death certificate be executed burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es e consequenca ol): P.O. Box 68760, attending phys for use as the Due to (or as e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detec 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wera eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy completion of cause of death? 1 ☐ Yes 2 🛣 No 1 Yes 2 No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4□ Nursing Homa 5 🖫 Residence 6 □Other (Specify) Certification: To 1 Yes 2₺ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? 1 ☑ Natural 5 Pending Investigation n 24 hours after death.

Ne Funeral Director: Aft pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida Hospital 29a. Cartifier Medical 1🖾 Certifying Phyelclan: To tha best of my knowledge, daeth occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature end tine of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 27, 2000 D37975 20 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 10801 Lockwood Drive, #280, Silver Spring, MD 20901-1557 Jeffrey P. Indrisano,

DHMH 16 Rev 6/95

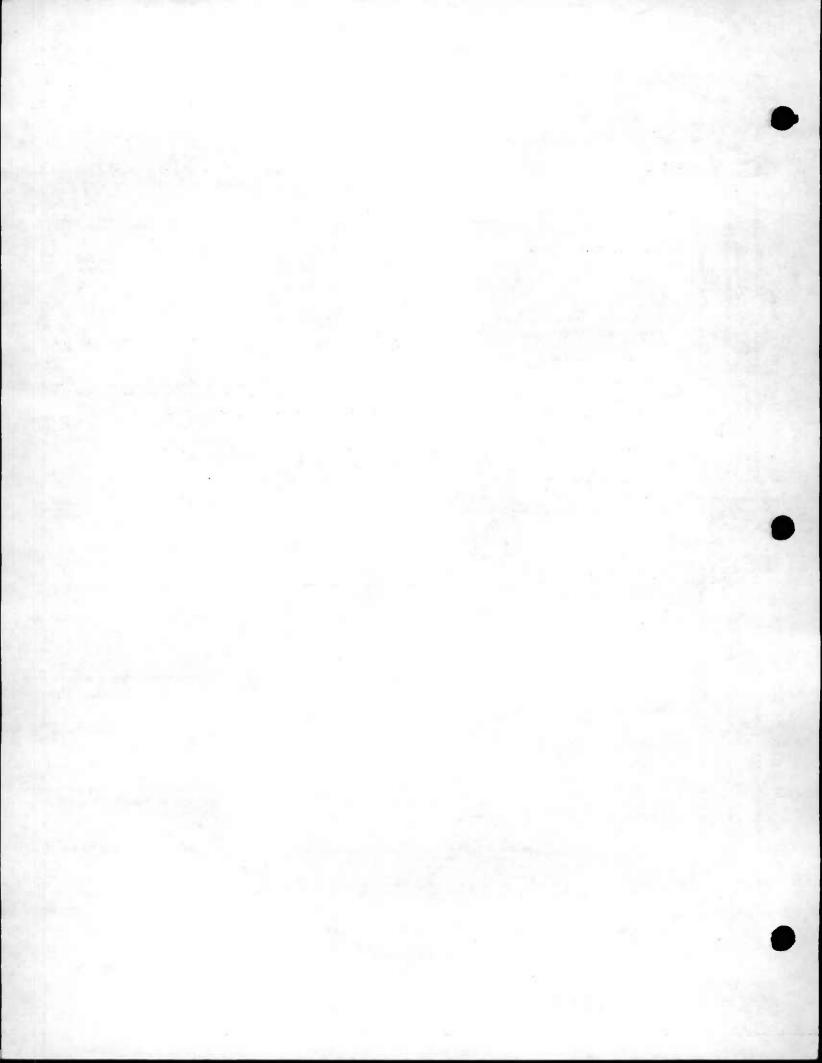
State

Registrar

31. Date filed (Month, Dey, Year)

APR 28 2000

32. Registrar's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaar 31500 2544 4b. City, Town, or Location of Death 2000 Sylvia Fechter 4a Facility Name (If not institution, give streat and number) 4c. County of Death The Hebrew Home of Greater Washington Rockville Montgomery If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Hours Days Months 1 M 2 XF 578-84-2476 88 May 11,1911 Poland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d, Insida City Limits 1 Yas 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6121 Montrose Rd. 20852 United States 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Ricen, atc.) Race - Amarican Indian, Black, White, etc. 1 Yas 22 No If Yes, Give Yaar or Datas: 1 Naver Marriad 2 Married 1 ☐ Yas 2 ☒ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Issac Newman Chaya Dvora (Unknown) 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) Dr. George Fechter/Son 2119 Edgewater Pkwy Silver Spring, MD. 20903 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata tx Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4/28/00 4 ☐ Donation 5 ☐ Othar (Specify) Lebanon Cemetery Adelphi, MD. 22. Name and Address of Facility Stein Hebrew Memorial. 21. Signature of Funeral Service Licen 232 Carroll St. NW Washington, DC. 20012 Part 1. Enter osaasa, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onsat and Daath Immediata Cause (Final Cardio-pulmono disease or condition rasulting in death) Dua to (or as a consequence of): (ovonon Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consaquanca of): aspirotors my econonia Due to (or as a consequenca of): that initiated avants rasulting in death) Last Stage Cachol Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 9 accome 25. Was casa rafarrad to medical examinar? 1 Tas 20 No 1 Yas 2 No dysphage 26. Placa of Death (Chack only ona) Othar: A Nursing Homa 5 Rasidence 6 Othar (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "nature!", or items 23a or 28a-1 show any fulur or other traumetic event, the Medical Examiner must be notified at once.

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The lew requires that the death certificate be executed physician end s the bunel-transil ettending p signed by the e Hospital or Attanding Physician:

Records, P.O. Box 68760.

After this certificate hes funeral director, page 2 Director

Physician/Medical Examiner Completed by Be

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29b. Signature and title of certifian

Certification: To

Medical

2 Accidant 6 Could not be datarmined 3 Suicida 4 Homicida 29a. Certifier (Check only one)

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28e. Date of Injury (Month, Day Year) 28b. Tima of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28d. Dascribe how Injury occurred 1 ☐ Yas 2 ☐ No Location (Straat and Number or Rural Route Number, City or Town, Stata)

Certifying Physician: To the bast of my knowledge, daath occurred at the time, data and place, and dua to tha causa(s) and mannar as statad.

Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at tha tima, date and place, and due to tha causa(s) and mannar statad.

28c. Injury at Work?

29c. Licansa number

th 2000

29d. Data signed (Month, Day, Year)

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

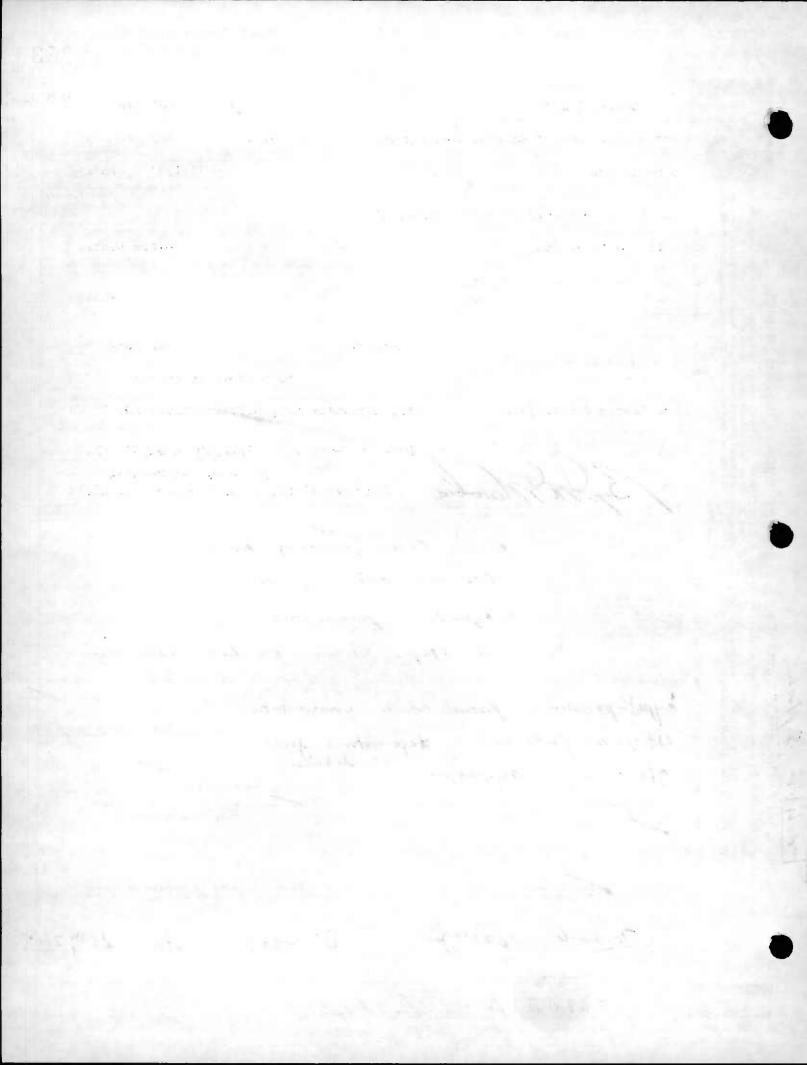
6121 Montrose Road; Rockville, MD 20852 Consuela Alverez, M.D.

State Registrar 31. Data filad (Month, Day, Yaar) APR 27 2000

32. Begistrar's Signatura

24 hours

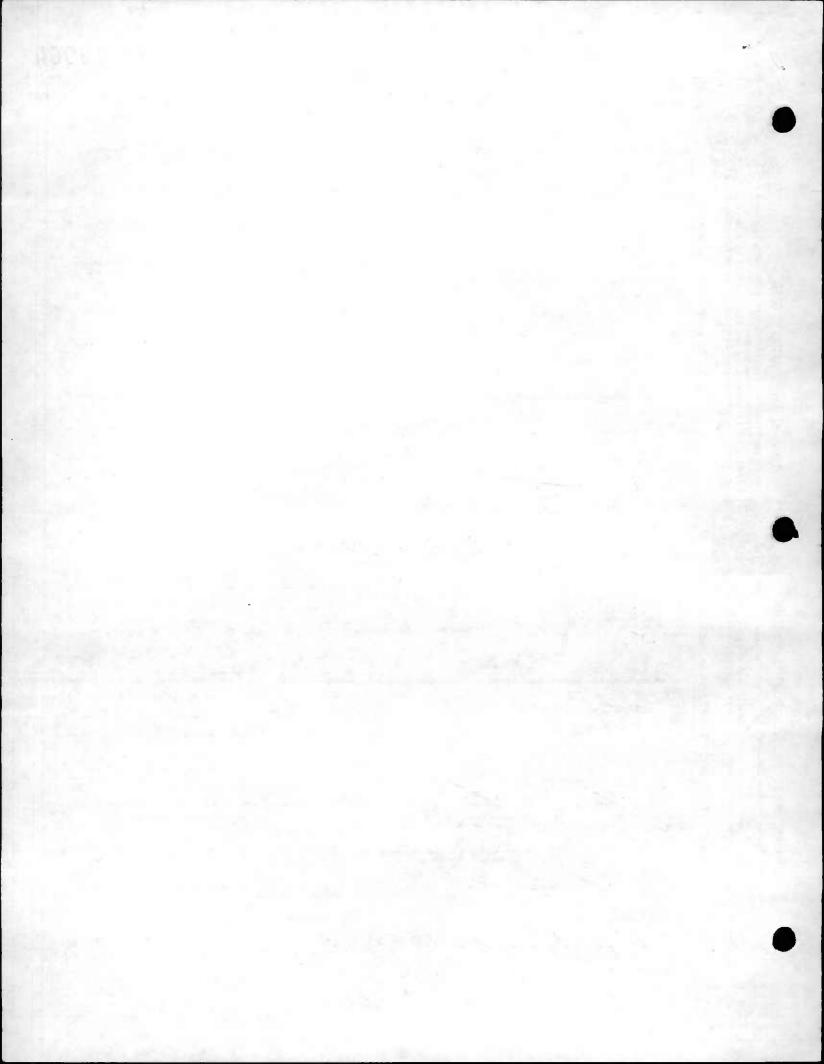
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## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** S'YLUAN Month 2:20 PM FEIGENSON 4b. City, Town, or Location of Death 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | May 18, 1915 5. Social Security Number 9. Birthplece (State or Foreign Country) Pennsylvania 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□ F 84 Yrs. 183-01-7365 Director Usual Residence of Decedent permit. Pages 1 and 2 ahould be filed within 72 hours after death with the Marylend Depertment of Health and Mantel Hyglane. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any jointy or other traumatic event, tra Madical Examinar must be notified at page. 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Silver Spring 1X Yes 2 □ No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20901 U.S.A. 11010 Lombardy Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 287 No Specify: P Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supervisor 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Israel Feigenson Dora Snowvice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2015 Windham Ln., Wheaton, MD 20902 David Feigenson/ Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) Apr.24 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removat from State King David Memorial Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner to (or as a consequ Physician/Medical Examiner The law requires that the death certificate be axecuted ed by the attending physician and datached for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. ģ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy is certificate has director, page 2: 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director; to Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 N 1 Dinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 (Natural 1 | Yes 2 | No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 2309 SHORE IELD RI of death (Item 23a) (Type, Print) MYRUN WHEATON, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souls **APR 25** 2000 Registrar



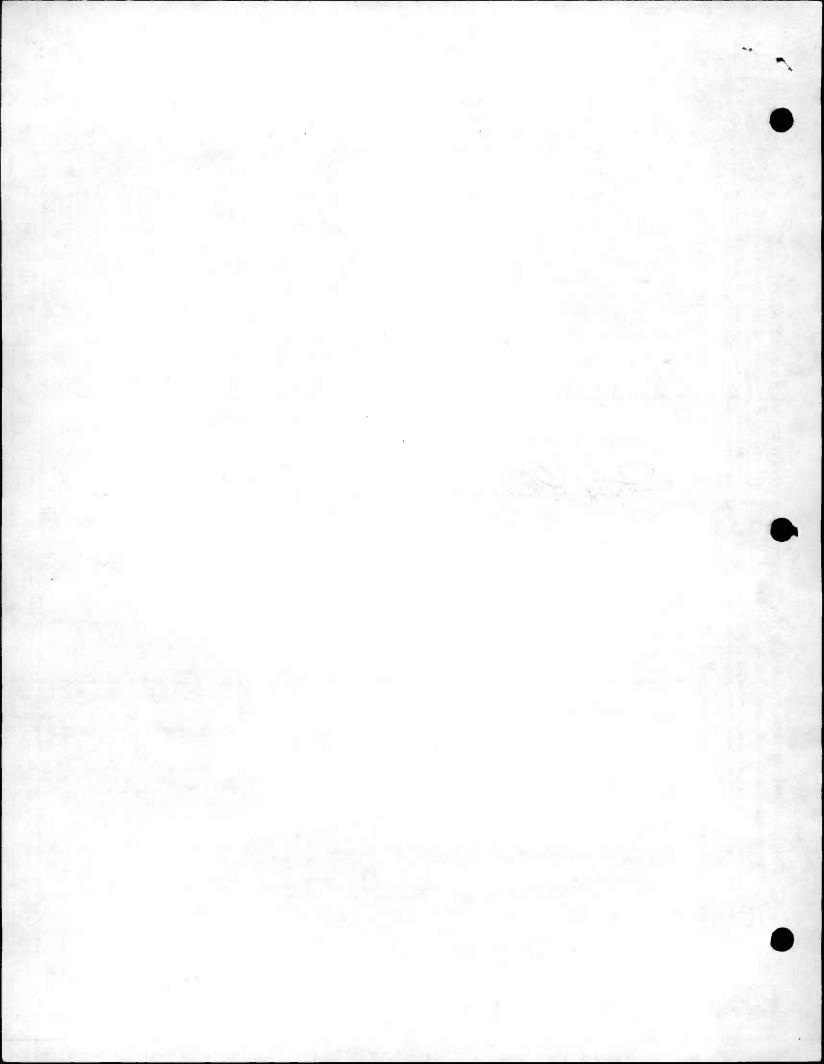
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				,/			- 0 2171				

State Registrar

31. Dete filed (Month, Day, Year)
APR 25 2000

Michael J. Hawkins M.D. 110 Irving St. NW Washington, D.C. 20010-2975

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 14966 Certificate of Death Amend #26,4/25/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Doris Draper Fox 10:05 AM April 20, 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Golden Years Care Facility Lothian Anne Arundel Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 20,1922 If Under 1 Year 9. Birthplace (State or Foreign Country)
Washington D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 K F 214-34-6539 Yrs Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any liquy or other traumatic event, the Madical Exeminer mast be notified at Pages. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No Director Md. P.G. College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6905 Wake Forest Dr. 20740 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ∰Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Tech. Fed. Gov't. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 J. Draper Minnie Waldau 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Stephen J. Fox (Son) 6905 Wake Forest Dr. College Park, Md. 20740 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removat from State 14/22/00 Ft.Lincoln Cemetery Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Chambers Funeral Homes, P.A. 21. Signature of Funeral Service License 4670 nambre 5801 Cleveland Ave. Riverdale, Md. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Causa (Final disease or condition resulting in death) /Medical Alzheimer's dementia Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 995 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown þ cate has been sign. . page 2 should b 24b. Wera autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completally filled in by the funeral director; I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Nother (Specify) Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 SNatural
2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Descripting Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to the causa(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40210 4-20-2000 L. BROOKS, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, River 34 Owens ville West 20778 MD

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State

Registrar

31. Date filed (Month, Day, Year)

APR 25 2000

32. Hagistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** Jeanne C. Fried 2000 April 16, 9:00 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manorcare Westwood Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1∏M 287 F 82 Yrs. Director 185-01-6480 Sep. 5, 1917 Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1√2 Yes 2 No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5151 Ridgefield Rd. 20816 U.S.A. Funeral deeth 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Race - American Indien, Bleck, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours effer d
Department of Heelth and Mentel Hygiene.
Important: If item 27 is marked other than "natural; or item
eny injury or other treumatic event, the Mescal Exempted. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samuel Corson Ella Bogutz 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20008 Victor C. Fried/ Son 4707 Connecticut Ave., NW, #115, Washington, DC 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State D 1 ☐ Buriel 2 In Cremetion 3 ☐ Removel from Stete Apr. 20, Mt. Comfort Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2000 Alexandria, VA 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Danzansky-Goldberg Memorial Chapels, 1170 Rockville Pike, Rockville, MD 20852 Approximete Intervel Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Chronic Obstructive Pulmonary Disease vears Examiner Due to (or es e consequence of): ME. OIENH Physician/Medical Examiner Tobacco Use 50+ years attending physician end for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (er.as a consequence of): P.O. Box 68760. physician that initieted events resulting in death) Lest Due to (or as a donse Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1⊠ Yes 2□ No 3 Probably 4 Unknown Osteoporosis, status post hip fracture Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? should Be Completed 24a. Wes an autopsy peed pege 2 1 Yes 2 No 1 Yes 2 No certificate of Vital or Attending Physicien: funerel director. 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After 1 Neturel 5 Pending after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier April 19, 2000 0

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State

Registrar

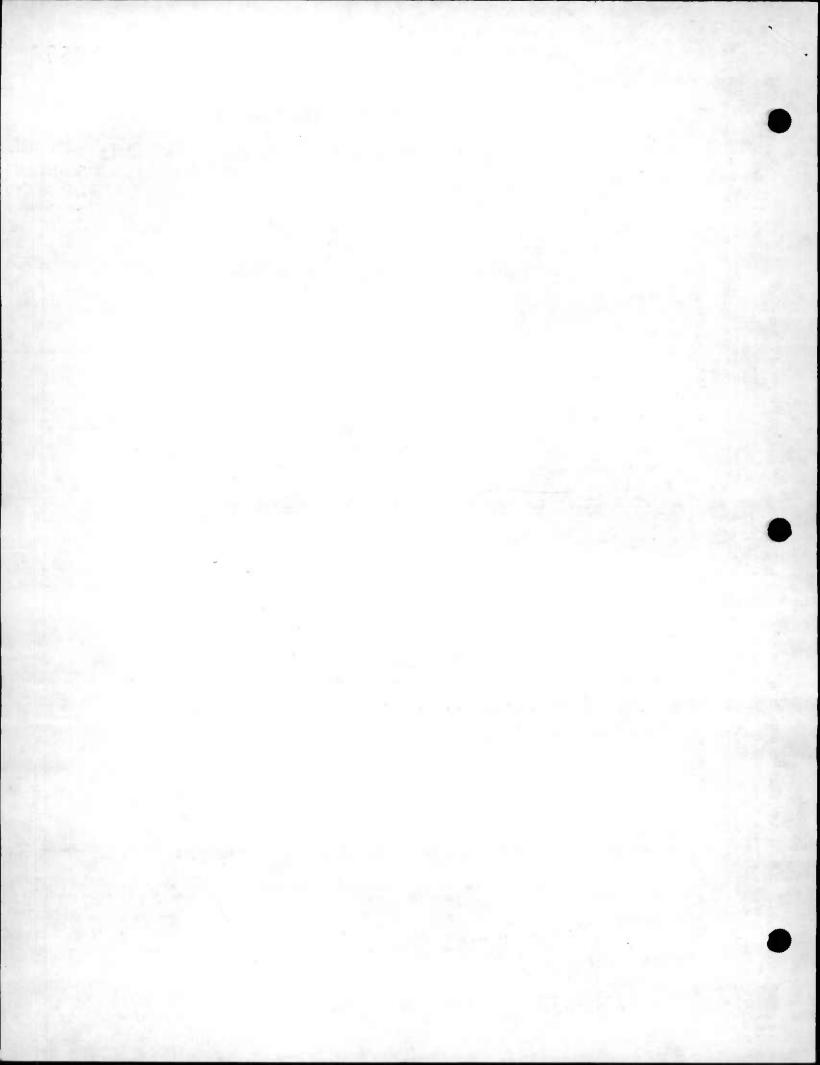
Susan J. Miller, MD 6844 Tulip Hill Terr., Bethesda, MD 20816

32. Registrer's Signeture

30. Name end eddress of person who completed cause of deeth (Ilem 23e) (Type, Print)

31. Dete filed (Month, Day, Year)

APR 25 2000



#### Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14968 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3 Time of Death Dey **Physician** 21, Naomi Ruth FRIEND April 2000 7:25 PM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3506 Glendale Road Swanton Garrett 5. Social Security Number If Under 1 Yaar | If Under 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Steta or Foraign Country) **Funeral** Months Deys Hours Min 1 M 2 TE Yrs. 212-24-2120 Director 72 July 2, 1927 Maryland Usual Residence of Decedent 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 1 ☐ Yes 2 ☑ No Director MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 'natural', or items 23a 3506 Glendale Road 21561 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 33No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 INo Specify: p Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Deperment of Health and Mentel hyglen important: if item 27 ie marked other tha any Injury or other traumatic event, the page. Homemaker 17. Fether's Neme (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumeme) Be Allen Timmerman Mabe1 Bittinger 19a. Informent's Neme/Raiatlonship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Garry L. Mayfield/Son 154 Booger Ridge Road, Swanton, Md. 21561 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Slete 4 ☐ Donetion 5 ☐ Othar (Specify) Glendale Cemetery 4/24/00 Swanton, Md. 21. Signature of Funeral Service Licensaa 22. Name and Address of Fecility Stewart Fuenral Home Onter 32 S. Second St., Oakland, Md. 21550 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Between Onset and Death **Physician** Failure Immediate Ceuse (Finel disaase or condition resulting in deeth) /Medical Respiratory Examiner Examiner physicien end s the burial-transit certificate be executed Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in deeth) Last Dua to (or as e consequence of): Box 68760. Physician/Medical Dua to (or es a consequence of) attending | P.O. 1 Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 12 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy page 2 s 1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes 2 ☐ No Division of Vitai or Attending Physician: 25. Wes case rafarred to medical Be 26. Place of Deeth (Check only one) Other: Nursing Homa 5 Residenca 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Affer Neturel 5 Pending death. To the Hospital or Attendit within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu 1 Yes 2 No investigetion 2 Accident 6 Could not be datermined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stere) 3 Suicide 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide JE Certifying Physician: To the best of my knowledge, daeth occurred et the tima, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred et the time, data end place, and due to the cause(s) end mennar steted. 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Daniel Miller, DO 69 Wolf Acres Drive, Oakland, Md. 21550

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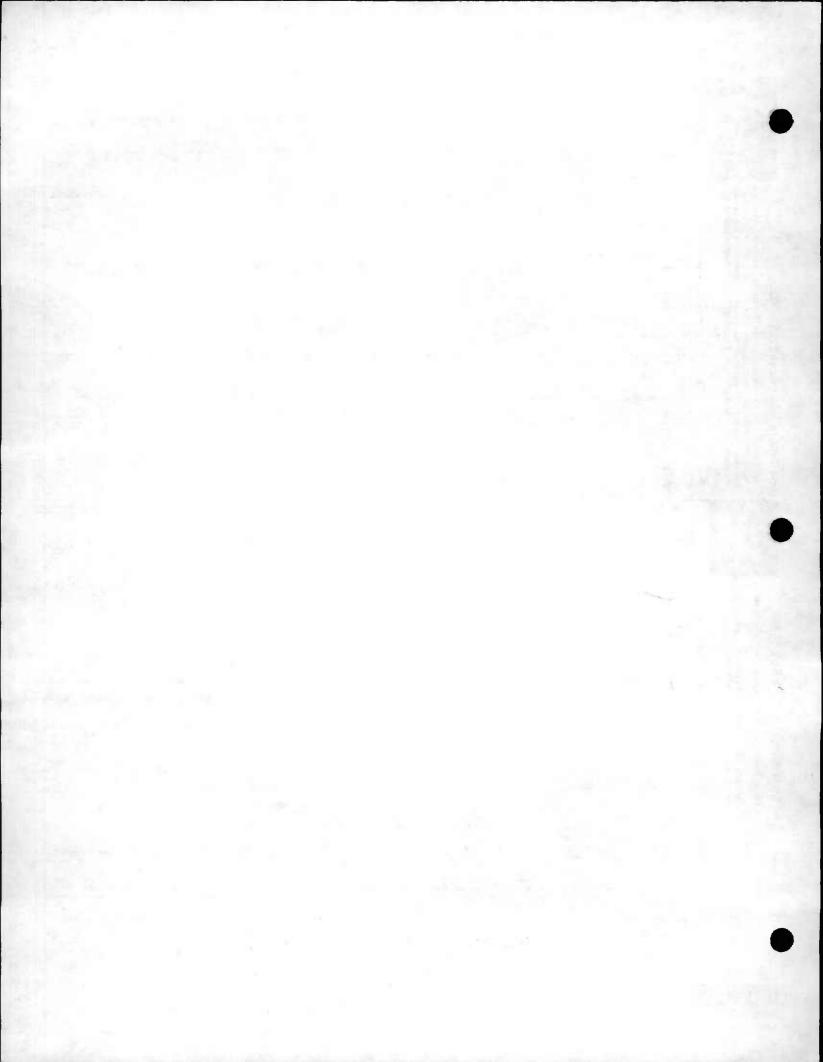
State

Registrar

31. Dete filed (Month, Day, Year)

APR 2 5 2000

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4969 Amended #17, #18, 5/8/00, LDB, Dor. Co. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima ot Death Day Vear **Physician** 122 Deat rice 2000 /Medical 4b Gity, Town, or Location of Death County of Death 49 Pacility Nama (If not Institution, giva street and number) 40 Examiner 6. Sex lal Ambrida Il Undar 24 Hrs. 8 chester Orchester 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Deys 1 M 2 F Months Hours 1-24-873 Alabama 2 421 Director Usual Basidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Tras 2 No Director orchester ambrida 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Dacedant Evar in U.S. 18. Armed Forcas? USA 34 2 Funeral 61 14. Race - Amarican Indian, Black, Whita, atc. 3. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 8 1 Yas 2 No Specify. à 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) Private Nanny Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be Mental Lula. Horace Tate is marked 2 Pages 1 and 2 should Luia Johnson Unknown 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Cambridge Beltway Cambridge, MD, 2/6/3 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) tem 27 niece Baltimore, 20a. Mathod of Disposition Data ō 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4/27/2000 4 ☐ Donation 5 ☐ Othar (Specify) Fairlawn Memorial Fairlawn New Jersey CeMetery 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Home P.A. Henry Funeral 23a. Part 1. Enfer tha disaese, or complications that caused tha days Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart tailure. List only one cause on aech line. MD.216 Approximata Interval Between Onsat and Death **Physician** /Medical tmmediata Causa (Final disaasa or condition rasulting in death) Examiner Examiner mas The lew requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in daath) Last mos Box 68760. physicien Physician/Medical Dua to (or as a consequanca of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown þ Records, 24b. Wera eutopsy tindings availabla prior to complation of ceusa of daath? 24a. Was an autopsy performad? Completed 1 Yas 2 16 1 ☐ Yas 2 No certificate of Vital Physician: 25. Was casa rafarrad to medical examiner? Be 26. Place of Daath (Chack only ona) Hospital: 1 Impatient Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No edical Certification: To 2 ER/Outpatient 3 DOA this 28e. Deta of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After Division Attending 1 Naturat 5 Pending invastigation deeth. 1 Yas 2 No spital or Attenditions after deeth. 2 Accidant 28t. Location (Street end Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 T Homicida To the Hospital within 24 hours a To the Funeral C completely filled Hospital 24 hours 8 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steled.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29e. Certifiar (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifian 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) 30200 ichn 2000 Segistrar's Signature 31. Data filed (Month, Day) Year State APR 26 Registrar

DHMH 16 Rev 6/95

APR 2 9 2000 January Mr. Africa

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 00-2455-021 State of Maryland / Department of Health and Mental Hygiene Eric W. Fischer Certificate of Death amend item 24a per G783 5/9/00 vg 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Eric W. Fischer May 02,2000 11:39 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick City
If Under 24 Hrs. 8. Date of B 542 Logan Street Frederick 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Months 10 M 20 F Yes Director 187-66-1359 30 AUgust 29,1969 North Carolina Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Show or 28a-f show 1 ☑ Yes 2 ☐ No Director Maryland Frederick Frederick 10s. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 234 828 E 16th Street 21701 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 8 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced peacetime Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Police Department 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Robert Fischer W. Catherine Carroll Pages 1 and 2 should 2 19a. informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mem 27 I Catherine Fischer - Mother 98 Fox Meadow Drive Erial. N.J. 20c. Location - City or Town, Stete 20b. Placa of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition Date Department of I Important: If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/8/00 Bell Mawr, N.J. New St. Mary's Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21214 Harbort aus Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complication, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceute of a line. Approximate Interval Between Onset and Death **Physician** Contact Gunshot Wound of Head /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Due to (or es a consequenca of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): physician s the burial Box 68760 Physician/Medical Due to (or as a consequenca ot): SE USB The law requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were eutopsy tindings evailable prior to completion of cause ot death? 24a. Was an autopsy performed? Completed 1⊠ Yes 2□ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case reterred to medicat 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other:  $_{4\square}$  Nursing Home  $_{5\square}$  Residence  $_{6}$ XXOther (Specify) Scene 10 1 Xes 2 □ No this funeral 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? Certification: Division Attending 5 Pending 1 Natural self-inflicted gunshot wound 1 Yes 2 No death. 5-2-00 1115 P Director: / 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 542 Logan 5+ 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide aftar ò nome Frederick Md To the Hospital within 24 hours of To the Funeral Completaly filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 03,2000 O.C.M.E. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Chutero J. lennis 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State MAY 9 2000 Registrar

DHMH 16 Rev 6/95

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Daveda Garver April 26, 2000 2:00 p.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Collingswood Nursing and Rehabilitation Ctr. Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Undar 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 25 F Yes 220-32-5670 96 April 7, 1904 South Dakota Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Meniel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f ahove pilouro or other traumatic event, in Medical Examiner must be not lied at ence. 1 Ves 2 □ No Directo Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2393 Bear Den Road 21701 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - Americen Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☼ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian Montgomery County Lib. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 10 Nels David Hansen Beda Westerlund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2393 Bear Den Road, Frederick, Maryland 21701 Robert Vernon Garver / Son 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 28,2000 Beltsville, Maryland Chesapeake Crematory Inc. 21. Signature of Funaral Sarvice Licenses Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. Stephen D. Lohrmann P.A. 20

23a. Parli. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 20910 Approximata Interval Between Onset and Death **Physician** /Medicat Immediate Cause (Final disease or condition resulting in death) 10 days a Aspiration Pneumonia Examiner Due to (or as a consequence of) Examiner Impaired Swallowing vear physician end the burial-trensit or Attending Physician: The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 ned by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ♥ No 3 ☐ Probably 4 ☐ Unknown Records, s been signer Completed by 24b. Were eutopsy findings available prior to complation of causa of deeth? 24a. Was an autopsy performed' page 2 1 Yes 2 No 1 ☐ Yes 2 No certificete Division of Vital director, Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA tha funerel 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel
2 Accident 5 Pending To the Hospital or Attending within 24 hours after death.

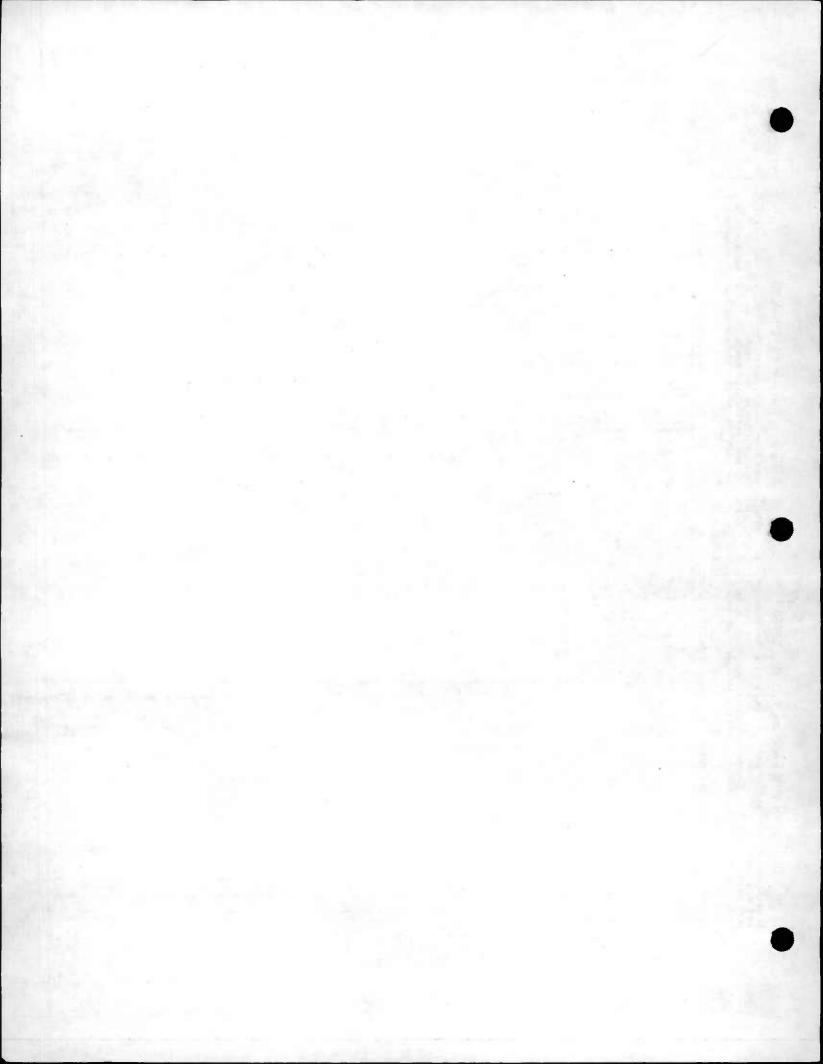
To the Funeral Director: After completely filled in by the fun. 1 Yas 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27830 3 April 27, 2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Ramleth T. Shakir; 9013 Shady Grove Court, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

APR 28 2000



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Day Month Physician 19, 2000 April 1940 Gaspare Giammetta /Medical 4b. City. Town, or Location of Daath 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Prince George's General Hospital Prince George's Cheverly If Undar 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 8. Date of Birth (Month, Day, Yaar) **Funeral** 1X M 2□ F Yrs Director July 2, 1922 Tunisia 578-56-9570 Usuel Residence of Decedant permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylen Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at once. 10c. City, Town or Location 10d. Insida City Limits 10a, Stata 10b. County 1 ☐ Yas 2 X No Directo Maryland Montgomery Olney 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 18101 Marksman Circle, #302 Funeral 20832 United States 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: Was Dacedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry International Elamentary/Secondary (0-12) College (1-4or 5+) Monetary Fund 12 Photographer 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be 2 Salvatore Giammetta Giovanna Scasso 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Massimo Giammetta/Son 16712 Calvary Drive, Rockville, Maryland 20853 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State Apr. 27 Gate of Heaven Cemetery 2000 Silver Spring, MD

22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License M00803 Rockville, Maryland 20850-2805 23a. Pert1. Enter the diseasa, or complications that causal the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Batwean Onsat and Death **Physician** /Medical Immediata Cause (Finel Minutes CARDIAC disaasa or condition resulting in death) Dua to (or as a consequence of) Examiner LARDIAC Sequentially list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEPSIS Physician/Medical Dua to (or as a consequence of) Aortic rott Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings available prior to completion of cause 24a. Was an autopsy Completed of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminar? . Place of Daath (Check only one) Be Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: Monatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Panding Invastigation 1 Neturel 2 Accident 1 ☐ Yas 2 ☐ No 6 ☐ Could not ba 3 ☐ Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mennar stated. 29a. Cartifiar

**Examiner** that the deeth certificate be executed law requires The Physician: or Attanding

death with the Meryland

physician and s the buriel-transit Box 68760 signed by the a Records, peen certificate has b director, this After this funeral within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

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29b. Signature and titla of certifian

29c. Licansa number 00052865 29d. Date signad (Month, Day, Year)

2000

30. Nama and address of persop who complated cause of death (Item 23a) (Type, Print)

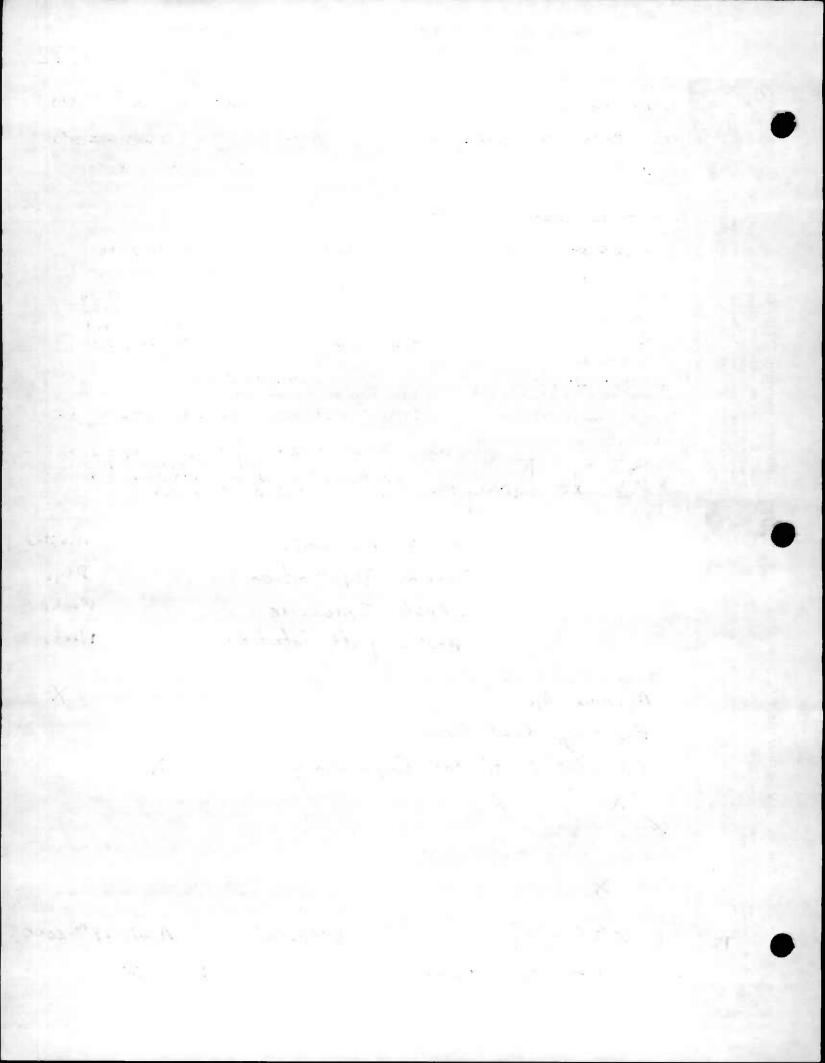
Michael Figaro, M.D.

3001 Hospital Drive, Cheverly, Maryland

31. Data filad (Month, Day, Year) State Registra

(Check only one)

APR 25 2000 32. Registrar's Signature



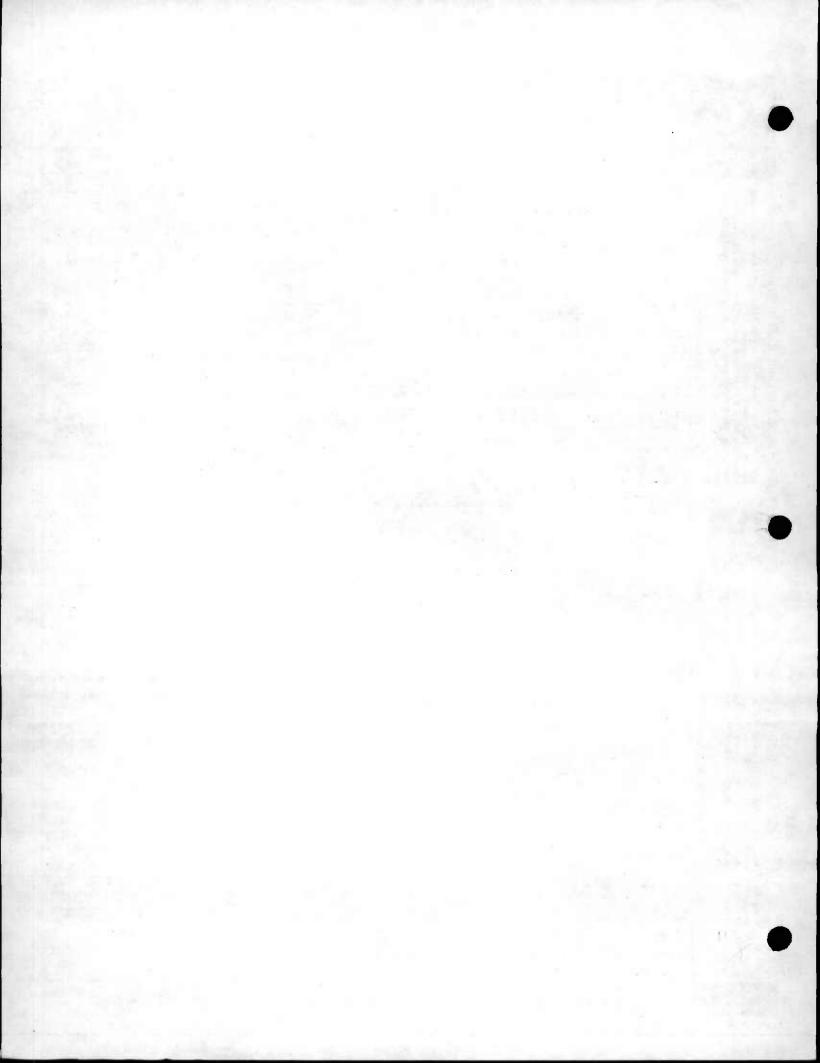
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2 Data of Death 3. Tima of Death Day Month **Physician** Nancy Ellen Grace 04 25 2000 8:00 am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3436 Canberra Street Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05 13 19 5. Social Security Number Birthplace (State or Foreign Country)
 PA 7. Aga (In yrs. last birthday) **Funeral** 1□M 2 F 206-40-4919 Yrs. 51 1948 **Director** Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show the notified at 1 ☐ Yas 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours effer deeth will Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, tra 3436 Canberra Street 20904 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ॐ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married Baltlmore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 5+ Principal Education 18. Mother's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be J. Robert Lawless Maryclaire O'Malley 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Donald J. Grace / Husband 3436 Canberra Street, Silver Spring, MD 20904 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Metropolitan Crematory 4/28/00 4 ☐ Donation 5 ☐ Othar (Specify) Alexandria, VA 21. Signature of Funaral Sarvice Licenses 22. Name and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd W., Silver Spring, MD 20901 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Death Physician Immediate Causa (Final disaase or condition rasulting in death) /Medical Generalized Carcinomatosis 2 months Examiner Dua to (or as a consequence of): Examiner Mestastic Breast Cancer 7 months or Attending Physician: The lew requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Breast Cancer 5 years P.O. Box 68760. Physician/Medical the th Dua to (or as a consequence of) USB BS signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by cate has been significant category category. 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? has 1 Yas 2₺ No 1 ☐ Yas 2 ☐ No certificate funeral director, Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) Certification: To 1 Yas 2000 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Panding invastigation To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: A 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 4 ☐ Homicide filled in Medicai 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifia D45274 4/26/2000 1 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Cho Maung, 10810 Connecticut Avenue, Kensington, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

APR 27 2000



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

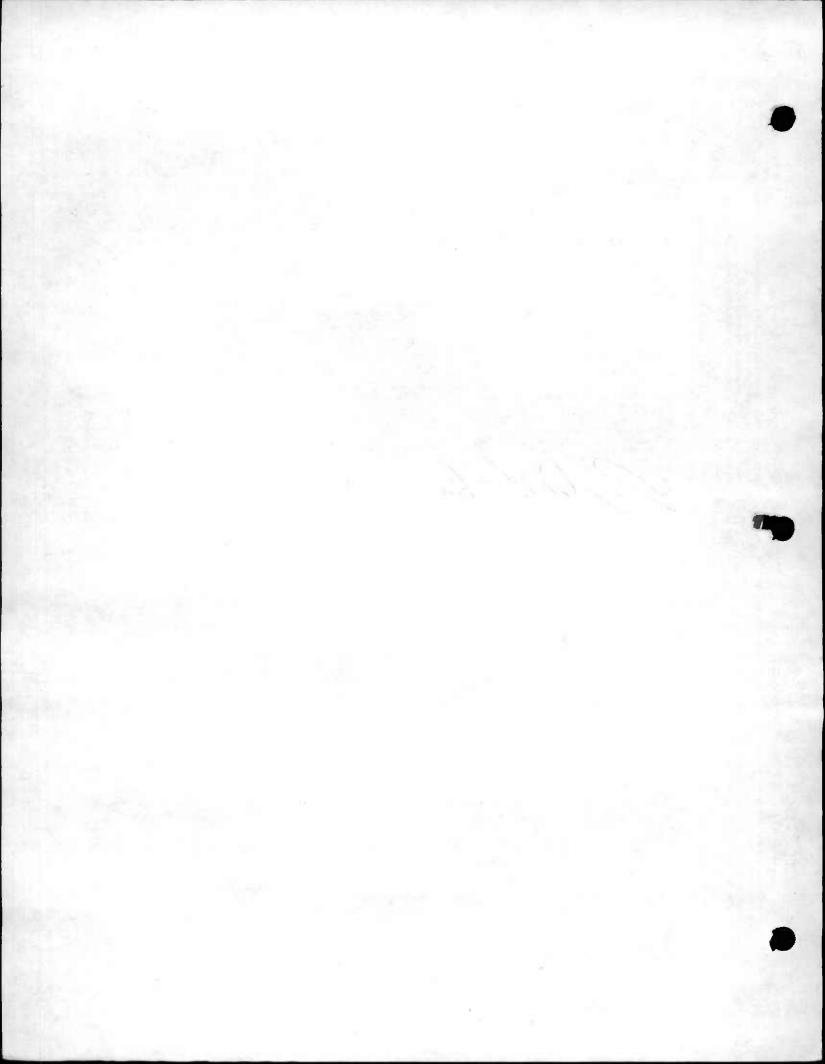
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3 Time of Death Month Year **Physician** 15 24. Sherry April Greenstein 2000 /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days Hours 1 □ M 2 ☑ F Yrs Director 578-36-1852B May 12,1913 Poland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nothed at 1,∏Yes 2 No Maryland Director Montgomery Rockville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda ò 6121 Montrose Road 20852 United States natural', or itema 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 □ Never Married 2 □ Married 1 Yes 2 No If Yas, Giva Yaar or Detas: 3altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify:White þ 3€1Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) permit. Pages 1 and 2 should be filed within 'Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "I any Injury or other traumatic event, I'm Mas Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mothar's Neme (First, Middle, Maiden Sumama) 17. Fether's Neme (First, Middla, Last) Be Zalka Eisenstein Pessa Weinapple 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pauline E. Barclay/ Daughter 14217 Piccadilly Road Silver Spring, MD 20906 20b. Place of Disposition (Nama of cematary, cramatory or other place 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Judean Memorial Garden 04/25/00 Olney, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fenaral Service Liverse 22. Nama and Addrass of FacilityStein Hebrew Memorial Funeral Home 232 Carroll St. NW Washington, DC 20012 23a art1. Enter the disaesa, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death hysician /Medical Immediata Causa (Final diseasa or condition rasulting in death) Cardio Examiner Dua to (or as a consequence of): Coronany Sequentially list conditions, if any, laading to immediate ceusa. Entar Underlying Ceuse (Diseasa or injury that initiated events resulting in death) Last and Dua to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. the BIPTON 2 No 3 Probably TUNKnown U toman Š signed L Vital Records, à 24b. Wara autopsy findings evailable prior to complation of causa of death? 24a. Was an autopsy Completed 25. Was casa ratarred to medical axaminar? 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate pettoro, disn Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient Other: A Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 3 DOA Division of 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Aftar or Attending Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fune 5 ☐ Pending 1 ☐ Yes 2 ☐ No invastigetion 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be datarmined Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar moule 30. Name end eddress of person who complated causa of death (120, 23a) (Type, Print) 20001 31. Data filed (Month, Day, Year) 32. Registrer's Signatura State APR 26 2000

Registrar

Deneva

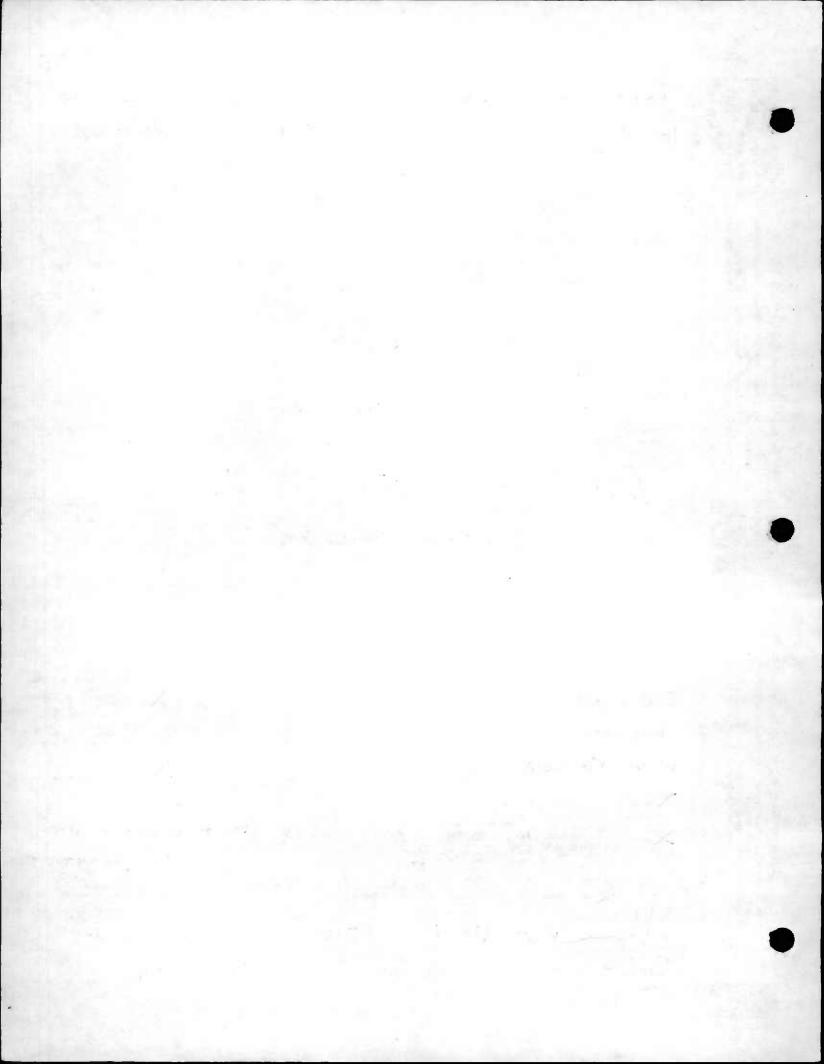


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Yaar **Physician** HELBY GROVEL LARSON 1145 20 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner SILUGA SPRING MONTSOMERY HOLY CROSS HOSATA Months Days Hours Min. 8. Data of Birth (Month, Day, Year) Feb 26, 19 Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1□M 2Ĭ F Yrs. 1916 Director 528-16-5535 Idaho 84 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 12037 Remington Drive 20902 USA natural, or items 23a Funeral 12. Wes Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yes, Give Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14. Raca - Amarican Indien. pemit. Pages 1 and 2 should be filed within 72 hours after a limportant: If Health and Mental Hygiene.
Important: If Health and Mental Hygiene.
any Initry or other traumatic avent, the Medical Exemples. Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Collega (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surneme) Joseph Larson Mona Milar 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Charles Glenn Grover - husband 12037 Remington Dr., Silver Spring, MD 20e. Mathod of Disposition 20b. Place of Disposition (Nema of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata Chesapeake Crematory 4/22/00 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD 20910 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarval Batwaen Onset and Death Physician INTRACEREBAN HEMORRIHATIS Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consaquence of): For Physician/Medical Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Dua to (or es a consequance of) P.O. Pert II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. DId tobacco use contribute to the cause of death? DIABBYES MOUTUS 1 Yes 2 No 3 Probably 4 Unknown signed to Records, ð 24b. Were autopsy findings aveilabla prior to complation of cause of death? Be Completed CHRONIC ROWER FOR URE 24a. Was en eutopsy performad? ATTUAL FIBRILL BOTON 1 Yes Division of Vitai al or Attanding Physician: Tis after death.

I Director: After this certificated in by the funeral director, pa 25. Was casa referred to medical 26. Pleca of Death (Check only ona) 1/2 Yes 2 No Hospitet: 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 27. Manner of Deeth 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Injury M. M 1 Natural
2 Accident
3 Suicide 5 ☐ Pending invastigation der by April + Bringlio Parko Meil 13 too 1 Yas 2 No 6 Could not be detarmined 28f. Location (Straet and Number or Flural Routa Number, City or Town, Stele) 12039 Rommily Count 28a. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b SILVE SONA, MO 1 Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and place, and due to the causa(s) end manner es stated.

The dical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29s. Certifier 29b. Sig and titla of certifier 29c. License number 29d. Date signad (Month, Day, Year) 015236 APRIL 21, 2000 15 30. Name and address of person who completed cause of daeth (Item 23a) (Type, Print) I. MARFOLD IM. O. 11125 ROCKVILLE PIKT, ROCKVILLE, MO 20852 31. Data filed (Morith, Day, Year)
APR 25 2000 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gnaedinger Lillian 7:00 pm April 24 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cavroll Cuthern Ullege Durson Verme

5. Social Security Number 6. Sex 7. As (In yrs. last birthday) If Under 1 Year

Months Days Virmi west minuteer If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 22 F 214-01-0496 Director 93 Usual Residence of Decedent deeth with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner maint be notified at 1⊠ Yes 2 No Directo Westminster MD ( Carroll 10g. Citizen of What Country? 10f. Zip Code 21158 USA 200 St. Luke Circle Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours affer a Department of health and Mental Hygiene. Important: If them 27 is marked other than "natural", or item any injury or other traumatic event. The same 1 Never Married 2 Married 1 Yes 2 No 1□ Yes 2□No Specify: Specify: White þ 3x Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk/Buyer Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Airing 2 Charles R. Welty 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 239 E. Main St., Westminster, MD Jeff Scott/attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29 Keysville Union Cem Keysville, MD ettire of Funeral Service Lice 22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician /Medical Immediate Cause (Finel Heure Pailure a. End Seuce Congesture
Due to for as a consequence of): disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed ettending physician end for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by 1 Yes 20 No 3 Probably 4 Unknown Chronce A. Pin þ

Completed Be Certification: To

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certificete

After this certifice funeral director, I

or Attending Physician:

death.

24 hours after death Funeral Director:

vithin 24 hour

filled in by

edicai pletely

23b. Did tobecco use contribute to the cause of deeth?

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes 20 No

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation

6 Could not be determined

26a. Date of Injury (Month, Day Year)

To the best of my kgd

On the basis of exp

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A3a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) wy the bauth occurred at the time, date end place, end due to the cause(s) and manner es stated.

Certifying Physician
2 Medical Examiner: 29a. Certifier (Check only one)

29b. Signature and title of certified

Naturel 2 Accident

3 Suicide

4 - Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who comd cause of death (high

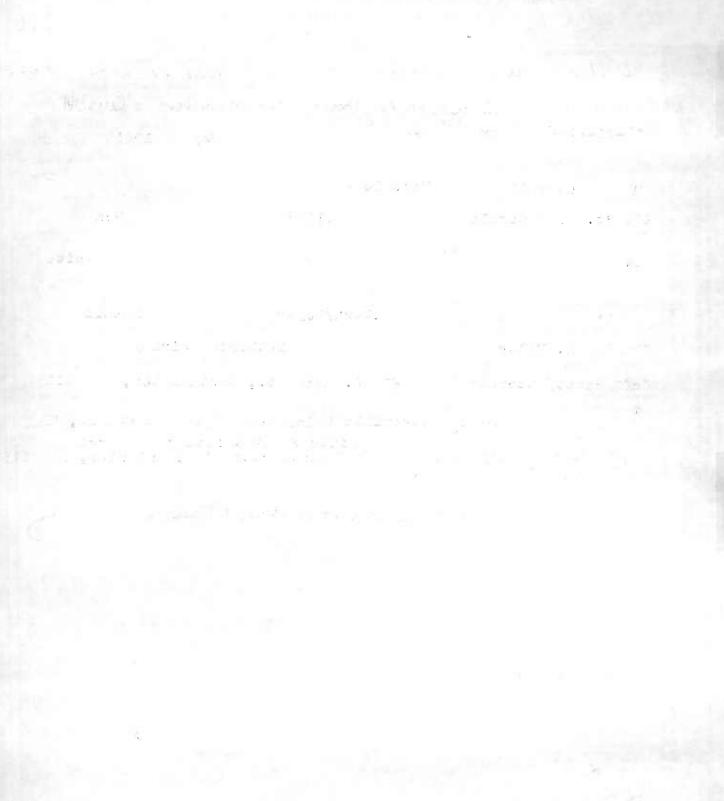
Alexander Brander

State Registrar

31. Date filed (Month, Day, Year) APR 2 6 2000

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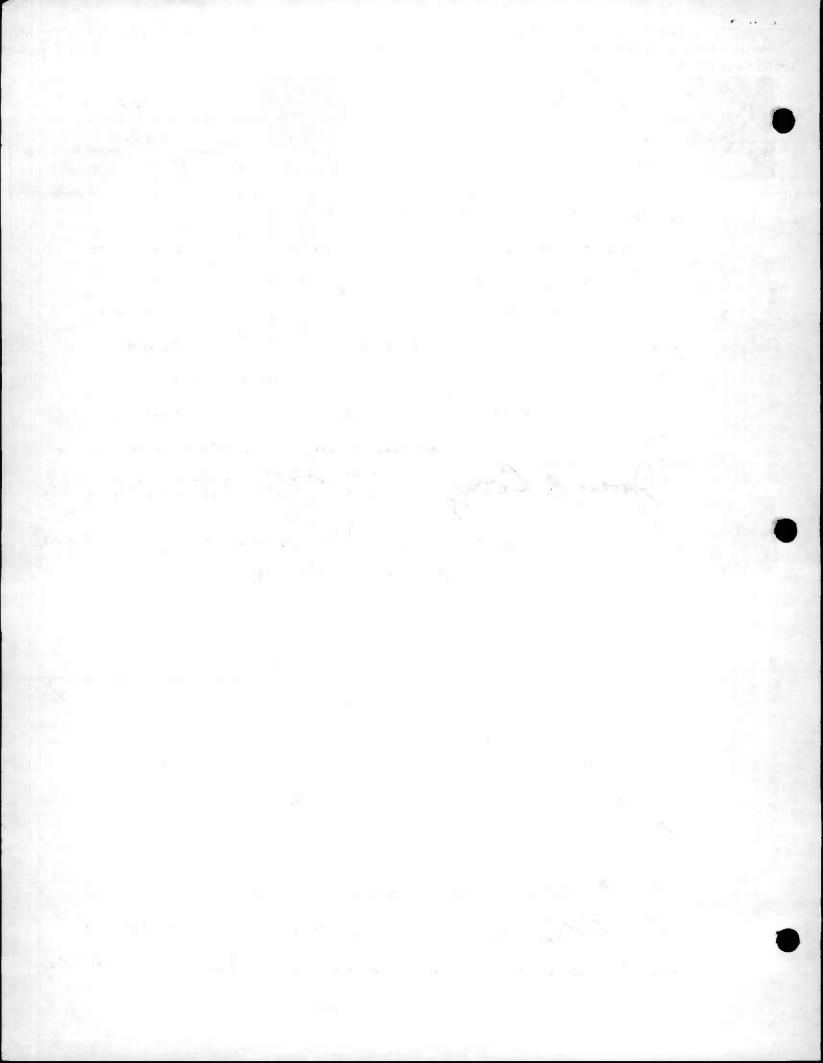
My westminder, Mul, 21157



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State of Maryland / Department of Health and Mental Hygiene 1 4 9 7 7

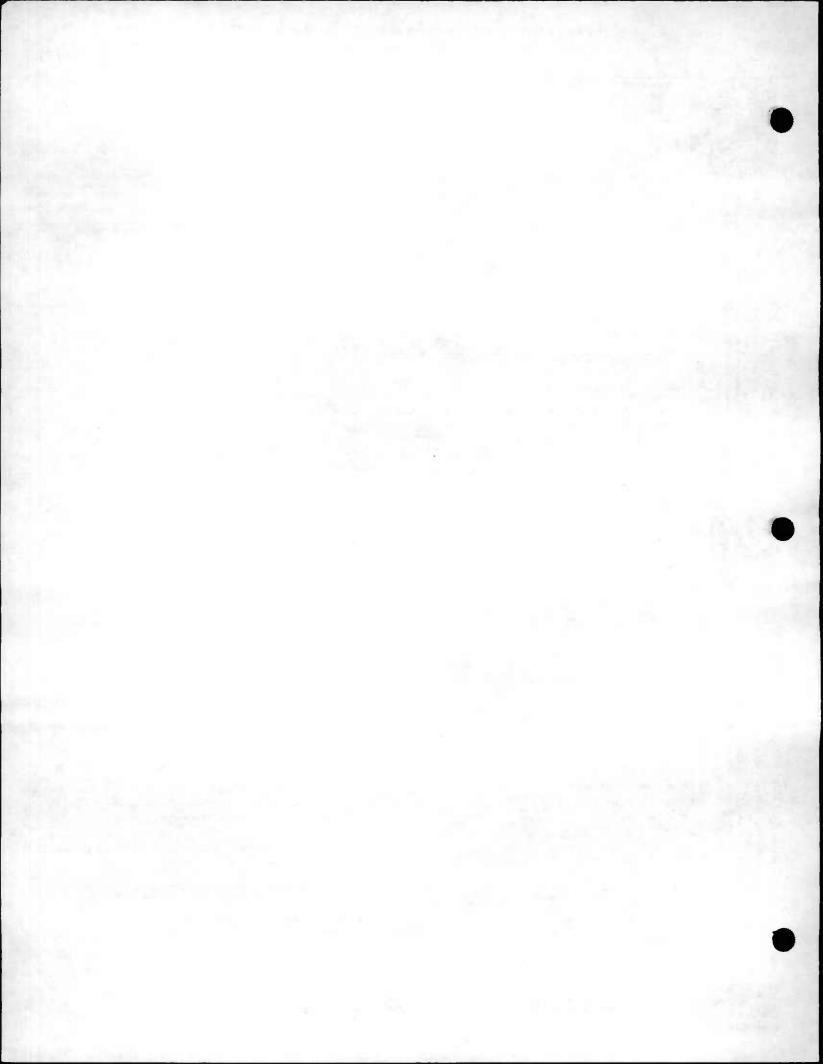
Sample   As Facility Name (if not institution, give street and number)   Ab. City, Town, or Location of Death   Ac. County   Manor Care   Social Sourity Number   6. Sax   7. Aga (in yrs. last birthday)   If Under 1 Year   If Under 2 Hrs.   8. Data of Birth   Months   Days   Hours   Min.   May 16 1927   May	9. Birthplace (Stata or Foraign Country) Maryland  10d. Insida City Limits 1 Yas 2 No What Country? States ca - Amarican Indian, ck, White, atc.  (y. White dusinass/Industry  DINE ma)  1, Stata, Zip Coda) 1, MD 21204 1- City or Town, Stata 2 rstown, MD			
Manor Care   April 24 2   Apr	2000 4:30 AM  y of Death  cimore  9. Birthplace (Stata or Foraign Country) Maryland  10d. Insida City Limits 1 □ Yas 2 ☒ No  What Country?  States ca. Amarican Indian, cky. White cusinass/industry  DIME  ma)  1, Stata, Zip Coda)  1, MD 21204  - City or Town, Stata  erstown, MD			
Scaling Name (If not institution, give street and number)   Manor Care   Balt Towson   Towson   Social Security Number   6. Sax   7. Aga (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Option 1 Sight   Months   Days   Hours   Min.   May 16   1927   May	9. Birthplace (Stata or Foraign Country) Maryland  10d. Insida City Limits 1 Yas 2 No What Country? States ca - Amarican Indian, ck, White, atc.  (y. White dusinass/Industry  DINE ma)  1, Stata, Zip Coda) 1, MD 21204 1- City or Town, Stata 2 rstown, MD			
Social Sacurity Number   216-58-2155   1	9. Birthplace (Stata or Foraign Country) Maryland  10d. Insida City Limits 1			
Director   Director	Maryland  10d. Insida City Limits 1 □ Yas 2 ☑ No  What Country?  States ca - Amarican Indian, ck, White, atc.  (y: White dusinass/Industry  DINE ma)  1, Stata, Zip Coda) 1, MD 21204 1- City or Town, Stata 2 rstown, MD			
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10a. Stata   10b. County   10c. City, Town or Location   10d. City, Town or Location   10d. Zip Coda   10d. City Town or Location   10d. Zip Coda   10d. City Town or Location   10d. Zip Coda   10d. City Town or Location   10d. Zip Coda   10d. City Town or Location   10d. Zip Coda   10d. Zip Coda   10d. City Town or Location   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   10d. Zip Coda   11d. Martial Status   11d. M	Mhat Country?  States  De - American Indian, lock, White, atc.  Ty: White  Susinass/Industry  DINE  MMD 21204  - City or Town, Stata  Erstown, MD			
Elamantary/Sacondary (0-12)    Collaga (1-4or 5+)   Housewife   Own housewife	Mhat Country?  States  De - American Indian, lock, White, atc.  Ty: White  Susinass/Industry  DINE  MMD 21204  - City or Town, Stata  Erstown, MD			
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Elamantary/Sacondary (0-12)    Collaga (1-4or 5+)   Housewife   Own housewife	ome.  ma)  n, Stata, Zip Coda)  n, MD 21204  - City or Town, Stata  erstown, MD			
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Due to (or as a consequence of):    Continued	ma)  o, Stata, Zip Coda)  o, MD 21204  - City or Town, Stata			
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Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Dua to (or as a consequence of):    Continued	MD 21204 - City or Town, Stata			
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Examiner   Medical   Examiner   Medical   Due to (or as a consequence of):    Compared to the consequence of the	MD 21204 - City or Town, Stata			
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Due to (or as a consequence of):    Continued	- City or Town, Stata			
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Due to (or as a consequence of):    Continued	erstown, MD			
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Due to (or as a consequence of):    Continued				
Physician /Medical Examiner  Physician /Medical Examiner    Medical   Examiner   Medical   Due to (or as a consequence of):    Continued	DΛ			
Physician /Medical Examiner    Continuous of the disease of complications that caused in death. Do not anter the mode of dying, such as cardiac or respiratory arrest,				
Physician /Medical Examiner  Immediata Causa (Final disaasa or condition rasulting in death)  A METASTATIC CARCINO MA  Dua to (or as a consequence of):				
Medical Examiner  Immediata Causa (Final disaasa or condition rasulting in death)  Immediata Causa (Final disaasa or condition rasulting in death)  a. METASTATIC CARCINO MA	Approximata Intarval Batween Onset and Daeth			
disaas or condition rasulting in death)  Dua to (or as a consaquance of):	MonRes			
Dua to (or as a consaquanca of):	rionnas			
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The second secon				
The cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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0 0 6 9 6				
Spanion of the state of the sta	entributa to the cause of death			
Part II. Other elignificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno			
Signature of the state of the s				
24a. Wes en eutopsy performed?  1	24b. Wara autopsy findings eveilabla prior to			
N m d s e l	complation of causa of daath?			
T = ₹ 8 8 1	1 ☐ Yas 2 ☐ No			
1   Yas 2   No  1   Yas 2   No  25. Was casa rafarred to medical axaminar? 1   Yas 2   No  26. Placa of Death (Check only one)  1   Yas 2   No  27. Wannar of Death  28a. Data of Injury  28b. Time of   28c. Injury at   28d. Describe how lower occurs.				
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28a. Data of Injury 28b. Tima of Injury at Work?	red			
Accidant Invastigation M 1 Yas 2 No 3 Suicida 6 Could not be 30 Blood felicity. A borne from short for the state of the st				
28a. Data of Injury At Work?  1 Anatural 2 Accident 1 Natural 2 Accident 3 Suicida 4 Homicida  28a. Placa of Injury - At homa, farm, streat, factory, offica  28b. Tima of Injury at Work?  1 Yas 2 No  28c. Injury at Work?  1 Yas 2 No  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)  28d. Dascribe how Injury occurs (Month, Day Year)				
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E = E = E   29b. Signatura and titled confider   29d. Dete signat	annar as statad. and dua to tha causa(s)			
D-12849 4-24	annar as statad. and dua to tha causa(s)  Id (Month, Day, Yaar)			
D-12849 4-24	annar as statad. and dua to tha causa(s)  Id (Month, Day, Yaar)			
D-12849 4-24	annar as statad. and dua to tha causa(s)  Id (Month, Day, Yaar)			
30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)	annar as statad. and dua to tha causa(s)  Id (Month, Day, Yaar)			



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 14978

			Ce	ertificate d	of Death		Reg. No.	1491	0			
Dhysisian	1. Decedent's Name (First, Middle, Las	•				2. Dete of Dea Month	ath Day	3. Time o	of Death			
Physician /Medical	William J	oseph Guder	john ,	Jr		April	21, 20	000 8:3	0 pm			
Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or I							
19	Long View Nursir	-		- Billadas I V	Manche			Carroll				
Funeral Director	220-22-6454	ex 7. Age (In yrs. 71	last birthday Yrs.	Months Da		8. Date of Birt (Month, De Oct 7,	y, Year)	9. Birthplace (State Country) Maryland	or Foreig			
pu s	Usuel Residence of Decedent  10a. Stete 10b. County	10c. Cit	ty, Town or L	ocation				10d. fnside (	City Limits			
e Maryli Ba-f sho ur c	Maryland Carro				Hampstea	d		1 1 1 1 1 1 1 1 1 1 1 1 1	s 211 No			
within 72 hours after deeth with the Maryland ene. 'ratural', or items 23a or 28a-f show the Madral Exercities must be notified at impleted by Funeral Director	10e. Street and Number 4005 Farmwoods La	ane		10f. Zip Cod	21074		10g. Citizen of W	/hat Country? SA				
	11. Meritel Status 1 Never Married 2  Merried 3 Widowed 4 Divorced	S. 13.	Was Decedent If Yes, specify ( 1 ☐ Yes 2 ②	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No o Rican, etc.)	14. Race Blace Specify:	e American Indien, k, White, etc. White					
72 ho	15. Decedent's Ed	lucation de completed)		edent's Usual Oc		king	16b. Kind of Bu	siness/Industry				
ed within 72 hours ygiene. or then "neture!, it, tre Medical E., Completed by	Elementery/Secondery (0-12)	(Specify only highest grede completed)  Elementery/Secondery (0-12)  Coilege (1-4or 5+)  2  (Give kind of work done done of life. DO NOT use retired)  Engineer						Telephone				
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should be and Mental a marked o umatic eve	William J. Guder	john, Sr			Cather	ine Weil						
475 P	19e. Informent's Neme/Relationship (1 Dorothy Guderjohr				reet and Number or Ru cods Lane,							
-755	20a. Method of Disposition	20b. F	Plece of Disp	osition (Name o		Date		City or Town, Stete				
0 0 - 5	1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Hemoval from State		ew Memo	rial Park	4/25		ville, MD				
pemit. Peg Depertment Important: I eny Injury o	21. Signeture of Funeral Service Licen	100723	- 2	22. Name and Ac	outh Main		uneral I					
	23a. Pert1. Enter the diseese, or companies shock, or heart tailure. List only	plications that caused the deet	h. Do not er			_			ete			
Physician /Medical	shock, or heart tailure. List only	one ceuse on eech line.						Approxime Intervel Be Onset and	tween Death			
	Immediate Cause (Final disease or condition resulting in death)  e Squamous Cell Cancer of lung											
Examiner	disease or condition resulting in deeth)	176	4/									
ē		Due to (c	or es a conse	equence of):								
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axec in an ial-tri	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury											
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at the death ced by the ettendii etached for use Physician/I												
the day the ached	Pert II. Other significant conditions co	ontributing to death but not res	ulting in the	underlying cause	given in Pert f.		23b. Did tobacco use contributa to the cause of de					
\$ 00 ×			10	3 Probably 49	Unkno							
as been s 2 should pleted				24a. Was an eutopsy performed? 24b. Were aut eveilable completic of death?								
	AND ME SECOND					101	res 2 No	1 ☐ Yes 2	No.			
certificate rector, pag	25. Wes case referred to medical				26. Place of Dea	th (Check only o	ne)					
	examiner? 1 Yes 2 No	Hospitat: 1 Inpatient 2 I	ER/Outpatie	ent 3 DOA	Other	lome 5□Resid		er (Specity)				
ang Ph h. After th funeral	27. Menner of Deeth  1 Naturel 5 Pending 2 Accident investigation	28e. Dete of fnjury (Month, Dey Year) 28b. Time of fnjury 28c. fnjury et Work?					now injury occurr		Y.			
or Atten efter deed Director: In by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t8f. Location (Street and Number or Rural Route Number, City or Town, Stete)									
n 24 hours n 24 hours ne Funerel plately filled edical C		ysicfan: To the best of my kno inner: On the besis of examine end menner steted.							(s)			
ithin of the omple	29b. Signature end title of certifier			29c. Lic	ense number		29d. Date signed	(Month, Day, Year)				
01 × 10 00 0	9				737573		1000	7000	20			
	30. Name and address of person who	completed cause of death (Item	n 23a) (Type				why	57,600				
	Jef Zibell N	NO 7250 B	ark 1	Heights	Ave bo	Himere	MD	80512				
State Registrar	31. Dete filed (Month, Day, Year) APR 2 5	32. Registrar's Signe	A A	5 do	ach							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 22° 2000 Frances Weikert Gorsuch 18:50 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Continuum Care Sykesville Carroll 5. Social Security Number If Under 1 If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan 16, 1901 Pennsylvania 6 Sex 7. Age (In vrs. last birthdev) 9. Birthplaca (State or Foreign 1□ M 2□ F Months Days 215-07-0230 99 Yrs Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll Sykesville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4512 Old Washington Road 21784 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 14. Race - American Indien, 11. Maritel Stetus Black, White, etc. ☐Yas 2 No 1 Never Married 2 Merried 1 Yes 2N No Specify: White Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Clothing 12 Dress Fitter 17. Fether's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Hoover Unknown 19e. Informent's Name/Reletionship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Mrs. Miriam Reed (Daughter) 4512 Old Washington Road Sykesvill, e MD 21784 20b. Place of Disposition (Name of cometery, cremetory or other place WoodLawn Cemetery 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Ramovel from State 4/26/2000 Baltimore, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signeture/of Funeral Service Licensee aigle Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one ceusa on each line. Approximeta Intervel Between Onset end Death tmmediete Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy 20 No

**Physician** /Medical Examiner

aftending physicien and for use as the buriel-transit

signed by t

certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Furerel Director: After this certifica completely filled in by the funeral director, is

The lew requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

Physician/Medical Examiner

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Be Completed

edicai Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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23a

"natural", or flems

filed within 72 hours after

permit. Peges 1 and 2 should be filed within 7. Department of Health end Mentel Hyglene. Important: if Item 27 is marked other than "na any injury or other treumatic event, the Mentel page.

Saltimore, Maryland 21215-0020

MD

Director

à

Be

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or injury that initieted evants that initieted evants resulting in death) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.

1 Yes 26. Placa of Death (Check only one)

1 Yes 2 No

25. Wes case referred to medical Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death 28e. Dete of Injury (Month, Dey Year)

28b. Tima of 28c. tnjury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

1 Neturel

3 Suicide

29a. Certifiar

2 Accident

4 Homicida

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) end menner steted.

29b. Signeture end title of cartifier

5 Pending investigation

6 Could not be determined

29c. License number D 51705

DR,

29d. Date signed (Month, Day, Year)

30. Name and eddrass of person who completed cause of deeth (Item 23a) Type, Frint)

M. PANSURIMA, HIGF Mallor

410F malwin westoninster, mozII5

State Registrar

31. Dete filed (Month, Dey, Year) APR 2 5 2000 32. Registrer's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Frederick Frank GEORG 17, April 2000 7:10 PM /Medical 4a. Facility Nema (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Daeth Examiner Dennett Road Manor Nursing Home Oakland Garrett If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) **Funeral**  Birthplaca (Steta or Foraign Country) 1 1 M 2 □ F Months Deys Hours Min. **Director** 220-10-1178 Nov. 2, 1917 Maryland Usual Rasidanca of Decedant deeth with the Meryland permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mantel Hygiane.
Important: If itsm 27 is marked other than "natural", or items 23s or 28s-f show say injury or other traumatic event, the Medical Examiner must be notified at once. 10a, Stata 10c. City. Town or Location 10d. insida City Limits MD 1 ☐ Yas 2 ☑ No Director Garrett 0akland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 1108 Hutton Road 21550 USA Funeral Was Decedant Ever In U.S. Armad Forces? 11. Marital Stetus Was Dacedent of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, etc. 1 □Yas 2 □ No If Yas, Giva Yaar or Detes: 1 ☐ Naver Married 2 ☐X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White ģ WWII 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12th Mechanic Auto Repair 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) Be Frank Georg Emma 2 Miller 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Evelyn M. Georg/Wife 1108 Hutton Road, Oakland, Maryland 21550 20b. Place of Disposition (Name of cemetery, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Zion Lutheran Ch. Cem. 4/20/00 Accident, Maryland 22. Nama and Address of Fecility 21. Signature of Funeral Sarvice Lin Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onsat and Death Physician /Medicai Immediata Causa (Final disaase or condition rasulting In daeth) Alzheimer's Dementia Months Examiner Dua to (or as a consequence of) Examiner attending physiclen end I for use es the burief-transit The law requires thet the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaase or Injury that initiated avants Due to (or as e consequanca of) P.O. Box 68760 Physician/Medical Due to (or es a consequança of) rasuiting in death) Lest signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHF Division of Vital Records. þ 24b. Wera eutopsy findings eveileble prior to completion of causa of death? page 2 should Completed 24a. Wes an autopsy **D990** certificate hes 200 No 1 Tas 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director. Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) examinar? Othar: 4 Nursing Homa 5 Residance 6 Othar (Specify) 1 Yas 2 No 2 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how Injury occurred Certification: Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident filled in by the 3 Sulcida 6 Could not be dataminad 28a. Plece of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata) 4 T Homicide 29a. Cartifiar Tecrtifying Physician: To tha best of my knowledga, daath occurred at tha time, date end placa, and dua to tha causa(s) end mannar as statad.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and pleca, end dua to the cause(s) end mannar stated. To the Hospi within 24 hou To the Funer completely fil Medical 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) H26154 30. Nema and addrass of person who complated cause of daath (Itam 23e) (Type, Print) P. Daniel Miller, DO 69 Wolf Acred Drive, Oakland, Md. 21550

State

Registrar

31. Deta filed (Month, Day, Year)

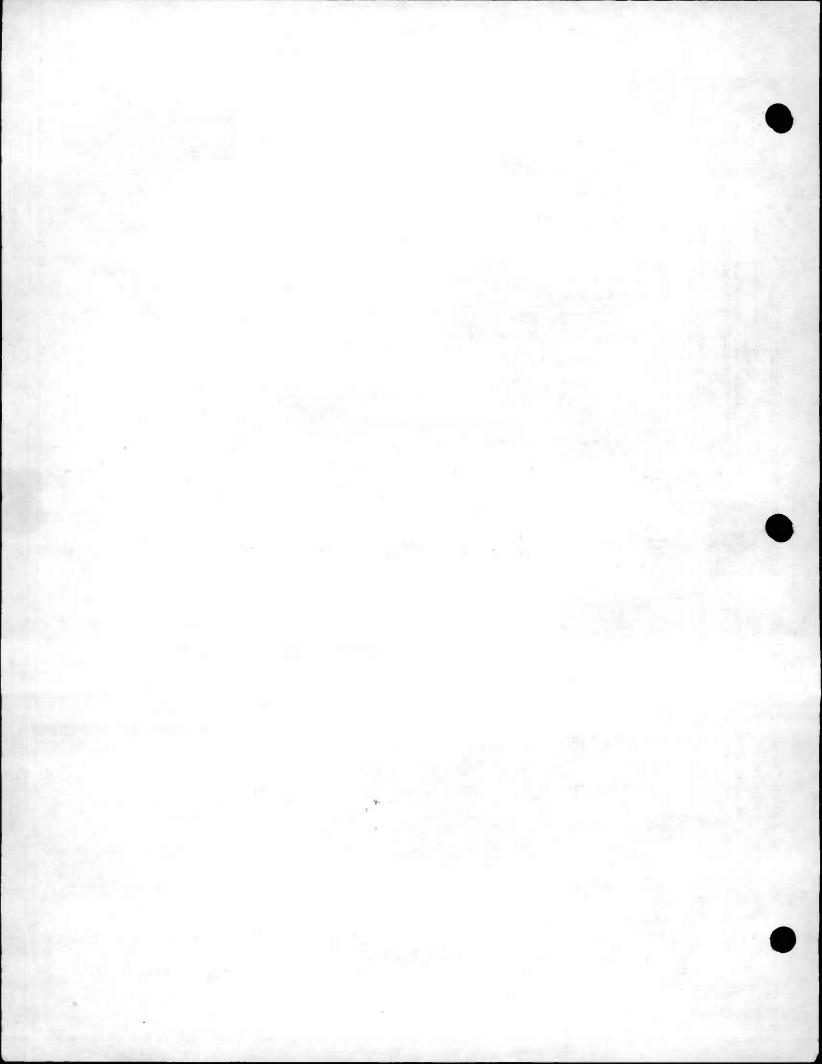
APR 2 0 2000

32. Registrar's Signature

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11, 001

				Certifica	te of	Death		Reg. No.		4901
1. Decedent's	Name (First, Middle,	Last)		2. Date of Dea Month	nth Day	Yaar	. Tima of Death			
Georg	ge Robert me (If not institution,	Hairston give street and number	)			4b. City, Town, or	April Location of Death		2000 of Death	9:00pm
	tland Nurs	ing Home				Adelphi		Princ	ce Geor	ge's
5. Social Secu		. Sex 7. A	ge (In yrs. last b	Months	er 1 Yaar Days	If Under 24 Hrs Hours Min.	8. Data of Birt	h i		a (Steta or Foreign
	4-4354 nce of Decedent	1 <del>∏</del> M 2□ F	63	Yrs.				12, 193		
10a. Stata	10b. County		10c. City, To	wn or Location					10d.	Insida City Limits
MD	Prince	George's	Ade1	phi						1 ☐ Yas ¾ ☐ No
MD 10e. Street and	d Number			10f. Z	ip Code			10g. Citizen of V	What Country	?
1801	Metzerott	T			2078			USA		
	Married 2   Married wed 4   Divorced	12. Was Decedent Armed Forces' 1 12 Yas 2 ☐ If Yes, Giva Year or Dates:	7			lispanic Origin? (S an, Mexican, Puar Specify:	Specify Yas or No- to Rican, atc.)		e - Amarican ck, Whita, atc. : Black	
	15. Decedent's (Specify only highest)			a. Decedent's Us	ual Occup	pation during most of wo	rkina	16b. Kind of Bu	usiness/Indus	try
Elementary/	/Secondary (0-12)	College (1-4or	5+)			during most of wo d)		26		
	6	and I		Plaste	rer	10 Mother's No.	ma (First, Middla,	Mainta		_
	ame (First, Middle, La						es.			1-
	<u>ie Joe Hai</u> It's Name/Relationship		19	b. Mailing Addra	ss (Street	And Number or R	Gravely ural Routa Number			
		irston-Wife				rive, Bas				
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	I 2 ☐ Cremation 3 tion 5 ☐ Other (Spe	☐Removel from State cify)	Carve	er Memor	ial	Gardens /	4/26/00	Martin	sville	, VA.
21. Signature	of Funeral Service Lic	censee	01	22. Nama	and Addre	ess of Facility	Metropol	itan Fur	neral S	Service
A	10 Nou 8 1	1600		5517	Vine	Street A	-			
23a. Part1. E	nter the disease, or co	emplications that cause by one cause on each	d tha death. Do	not entar tha me	da of dyi	ng, such as cardia	c or respiratory as	rast,	Ar	proximata arval Batween asat and Death
Sequentially II if any, leading cause. Enter Cause (Diseas that initiated e resulting in de		b		a consequence of						
Part II. Other s	algnificant conditions	d	out not resulting	in the underlying	causa gi	ven in Part I.	23b. Did	tobacco use co	ntribute to th	e cause of death?
Accu	intel Ho	man Imi	NUMBA	1066.6	In Cea	VILUS	10	Yes 2□No	3 Probet	oly 4⊡ Onknown
Den	neutra							an autopsy med?	availa	autopsy findings bla prior to lation of causa ath?
							10	ras 2 1 No	1 🗆 Y	es 2 No
	referred to medical					26. Place of De	eth (Check only o	na)	1	
25. Was case examiner?	2E No		ent 2 ER/C	Outpatient 3 0	JOA		Homa 5 Rasid	dance 6 DOth	er (Specify)	
27. Manner of 1 Nature 2 Accide	al 5 Pending investiga		ury 28b.	Tima of Injury M	28c. Inju Wo 1	ryat rk? ]Yes 2 □ No	28d. Describe	now injury occur	red	
27. Manner of 1 Natura 2 Accid 3 Suicic 4 Homis	dotormin									oute Number,
29a. Certifier (Check on ane)		Physician: To the best aminer: On the basis of and manner s	of axamination a							
	and title of certifier	2	0	2		se number		29d. Data signe		
8/2	land	worls	m		00	1852	/	SPRIZ "	222	000
30. Name and	A E F	ORE MA	death (Item 23a	(Type, Print)	5000	, Rd H	<u>l</u> attsvi	(c Mb	2078	21
31. Data filed	(Month, Day, Year)		rar's Signature	,						
	ADD 9 1 2	000								

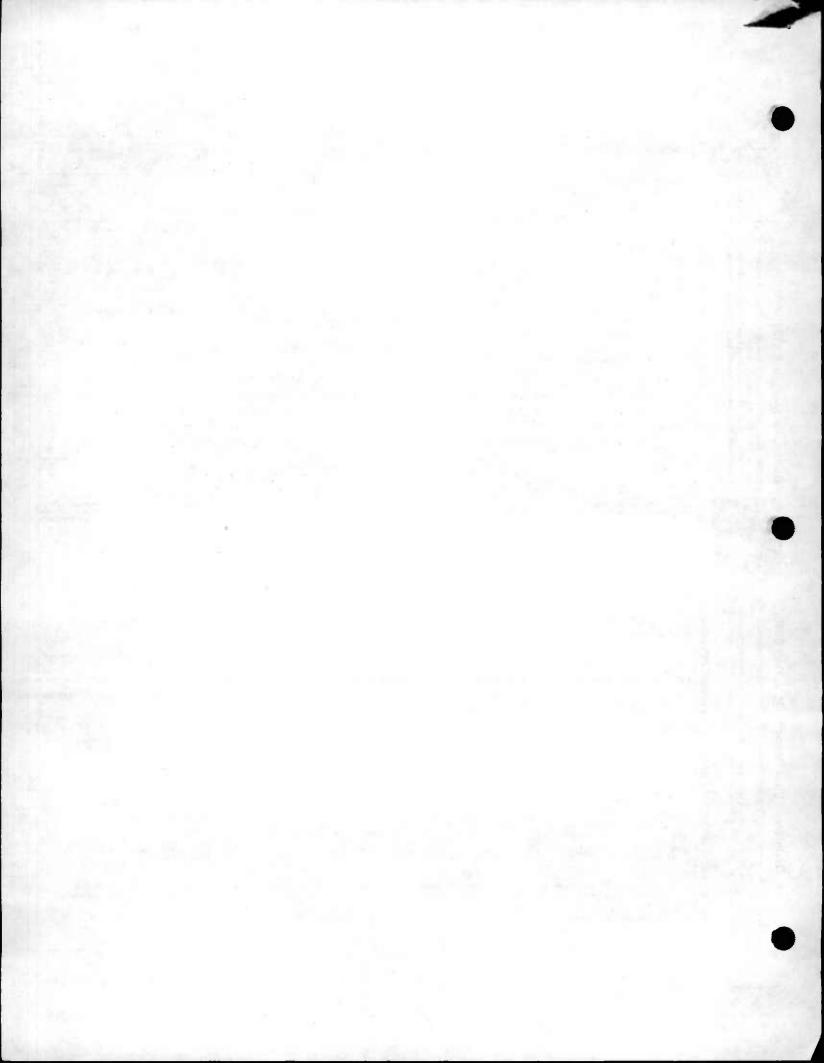
DHMH 16 Rev 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14982 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Death Month APRIL Physician CHARLES HALE HAYWOOD 12, 2000 9:53am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 620 Sheridan Street #308 Hyattsville Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) July 16, 1938 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Yrs 61 577-52-7221 Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits YOYes 2 No Director MD Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 8 a 23a 620 Sheridan Street #308 20783 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1⊠Yes 2□No 1957- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status permit. Pages 1 and 2 should be flad within 72 hours after to Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or has by follury or other traumatic event, the Medical Examines Base. 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 2 X No Specify: If Yes, Give Year or Detes: à 3 ☐ Widowed 4 ☐ Divorced 1977 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12th College (1-4or 5+) Housekeeper Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Haywood Hale Myrtle Ellison 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 620 Sheridan Street #308, Hyattsville, MD 20783 Geraldine Hale - Wife 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Ø Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cem. 4/20/00 Arlington, VA 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility R. N. Horton Co. Morticians, Inc. Vorton 600 Kennedy Street, NW, DC, 20011 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause of each tine. Approximete Intervel Between Onset and Death Physician Immediate Cause (Finet disease or condition resulting in death) /Medical a Lung lancer nonsmall cell metastatic to brain Examiner Due to (or es e consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted ng physician and as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): P.O. Box 68760. that initieted events resulting in death) Last Due to (or es e consequence of) been signed by the a should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3☑Probably 4☐Unknown Division of Vital Records. à 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 a 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? å 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Naturat 5 Pending investigation To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: After completely filled in by the fun 1 TYes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the ceuse(s) end manner stated. 29e. Cartifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 4/18/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MNMC House Mc Grail 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4983 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** Carl Matthew Harris Apri1 25, 2000 9:51am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foraign Country) **Funeral** Months Deys Hours 1XM 2□ F 110-30-3801 Yrs. 60 Director March 29,1940 New York Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits rai", or items 23s or 28s-f show Examiner must be notified at 1 Yas 2 Nio Funeral Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 12016 Whipporwill Lane 20852 United States Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 1 ☐ Never Married 20 Married 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry ntal Hygiene. ed other than ": sevent, me Me College (1-4or 5+) 5+ Elementary/Secondary (0-12) University Professor Education permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If them 27 is marked other any injury or other traumatic event and other. 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Benjamin Harris 20 Marion Neidiah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Alice Harris/ Wife 12016 Whipporwill Lane Rockville, MD 20852 20b. Place of Disposition (Name of cematary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Deta Burial 2 Cremetion 3 Removal from Stata B'nai Israel Cemetery 4 Donation 5 Other Spec 04/28/00 Oxen Hill, MD 21. Signature of Fuperal Se 22. Name and Addrass of Fecility Takoma Funeral Home 254 Carroll St. NW Washington, DC 20012 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** Arteriusclerotic Cardiovascular Disease, Due to (or es a consequence ot): Acute myscardial in farctim /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Did tobacco usa contribute to the cause of death? ate hes been signed by page 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings eveilable prior to completion of causa of deeth? Completed 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

certificate 4 hours after deeth Funeral Director: / 6 24 hours Funerei within 24 hor To the Fune completely fi

21215-0020

Maryland

Baltimore.

9:51Am

2002

April

- HARRIS

State Registrar

29a. Certifier

(Check only one)

Robert Rothstein 31. Data filed (Month, Day, Year) APR 28 2000

32. Registrar's Signature Rever

eled causa of death (Nem 23s) (Type, Print) 8600 Old Georgetown Road Bethesda, Maryland 20814 oaks

1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, date and place, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

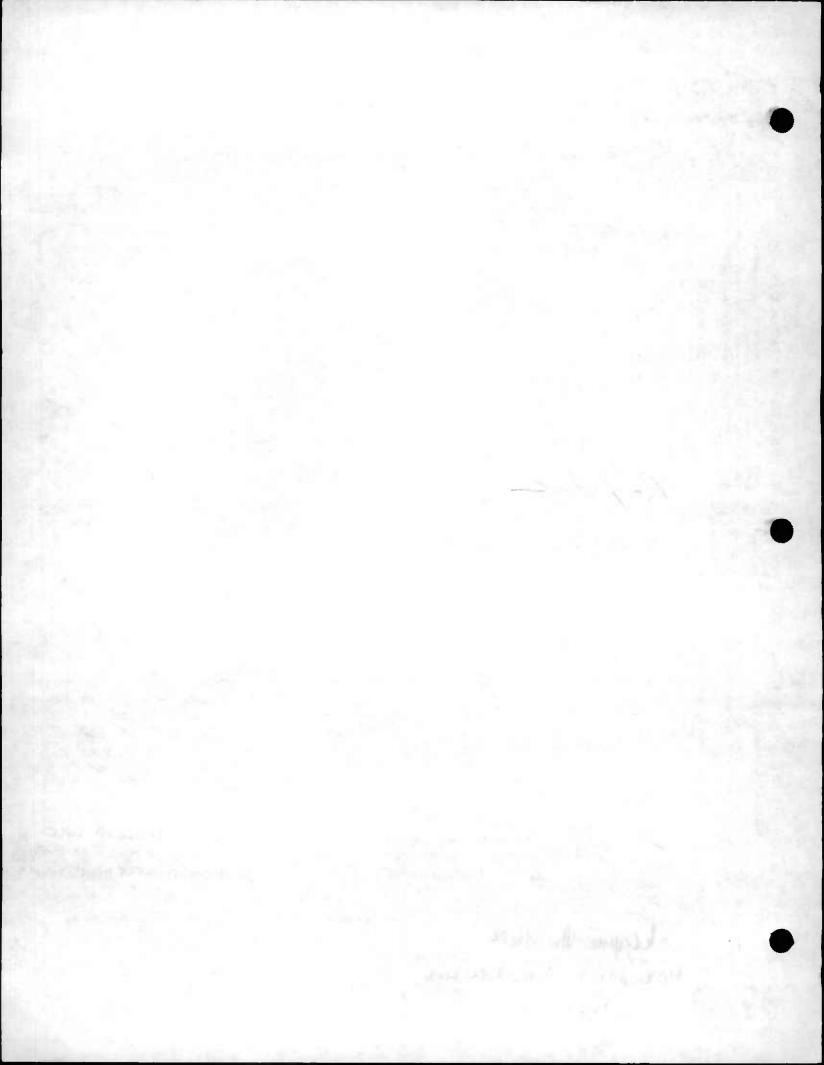
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State of Maryland / Department of Health and Mental Hygiene

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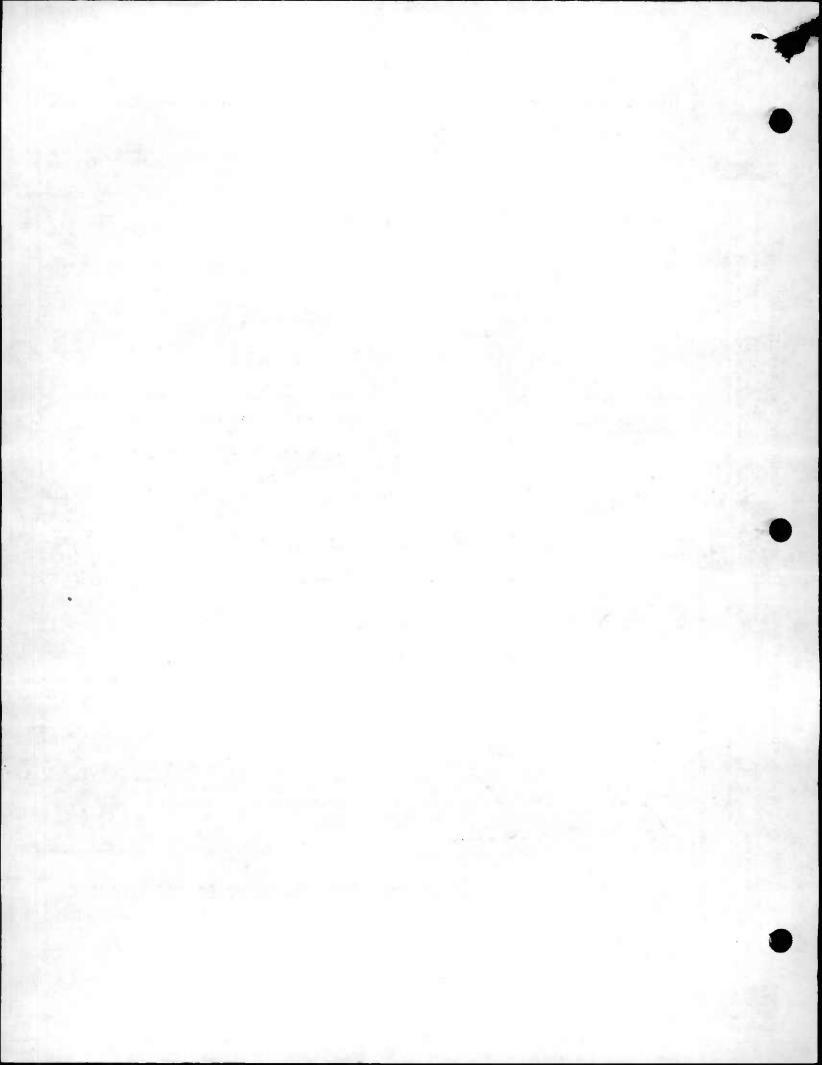
						Cei	rtificate	e of	Death			Reg. No.		
1		Decedent's Name (First, Mic	idle, Las	(t)		1"	d to				2. Dete of De Month	eth	Vanz	3. Time of Death
Physician /Medical	15	Cand	ida	Mary H	enrotte						April	L 22	2000	10:00 A.M
Examiner	40	Fecility Neme (If not institu	tion, give	street and nu	imber)		- 1		4b. City, To	wn, or Le	ocation of Deetl	4c. Count	y of Deeth	
		840	06 W	estmon	t Court					thes			gome:	ry
Funeral Director		Social Security Number 47–90–9809	6. Se	ex □ M 2	7. Age (In yrs.	lest birthdey) 8 Yrs.	If Under Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De May 22	th by, Year) 1951	9. Birth Cou Cal	plece (Stete or Foreign ntry) ifornia
arter death with the Meryland or items 23s or 28s-f show entired must be notified at foureral Director	1	uel Residence of Decedent												
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	104	a. Street and Number					10f. Zip					10g. Citizen of	Whet Cou	ntry?
	8	3406 Westmont	Cou	rt		2.194		0817					ted S	tates
		Marital Status  1 ☐ Never Married 2 ☒ M 3 ☐ Widowed 4 ☐ Divord		Armed F	2⊠No ive		Was Deced if Yas, spec 1 Yes 2			gin? (Sp ), Puerto	ecify Yes or No Rican, etc.)	Speci	ock, White,	can Indian, etc. ite
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Department of Health and Mentel thyglena. Important: if them 27 is marked other than "natural;, any injury or other traumatic evant, the Medical Ext once.  To Be Completed by	20	Method of Disposition     Disposition     Serial 2    Cremetic     Donetion 5    Other			State	Place of Disponentery, cres	netory or of	ther ple		Inc	pril 26, 2000	20c. Location Bethes		own, State aryland
Department of I important: If Ite any injury or of BRGs.	21	Signature of Funeral Servi	cellicens	500	M001	17	55/ W	isco	nsin	Avei	nue		ethes Chase	da-Chevy
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page 2											.6	Yes 2□No	,	Yes 2 No
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	-	axaminer? 1⊠ Yes 2□ No	-	Hospitel:	Inpatient 2	ER/Outpatier	3 DO	Oth	nor:		th (Check only	idence 6 🗆 O	ther /Snec	(64)
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within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		3 Suicide 6 □ Cou	Could not be determined						(	281. Location (Street end Number or Rurel Route Number, City or Town, Stete)			(50	
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within 24 hours To the Funers Completely fills Medical C	29		The	1 .	se of deeth (Ite				.C.M.:		altima	Apri	1 23	, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #23a-II.28.23b.24a&b.4/27/2000, BMW, Mont Certificate of Death cedent's Neme (First, Middle, Lest) 2 Date of Death 3. Time of Death Month **Physician** 4e Facility Name (If not institution, give street end number) argaret 4 : 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Universit 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sax **Funeral** Months Days 1 ☐ M 2 ☐ F Yrs Director 216-38-5895 Usuel Residence of Decedent Jan. 26, 1939 Ohio daeth with the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23s or 28s-f show 1 ☐ Yes 21 No Director Delaware Sussex Millville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Chad Place Funeral 19970 **USA** 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Race - American Indian 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) pemit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Emerina Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Kernan Dorothy Burns 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3032 Basford Road Joanne L. Hertz (daughter) Frederick, Maryland 21703 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 4/24/00 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feiture. List only one cause on each line. ames 500 University Blvd., W., Silver Spring, MD 20901 Approximate Interval Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires thet the death certificate be axacuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initieted events resulting in death) Last attending physician and for use es the burial-tran Due to (or es e consequence of): P.O. Box 68760, Due to (or es a consequence of) ata has been signed by the a paga 2 should be datached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Rheumatoid lung Records, Be Completed by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy 14 Yes 2 □ No certificata 1 Yes 20 No Division of Vital or Attending Physician; 25. Wes case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d, Describe how injury occurred 28c. Injury at Work? After 1 Neture 5 Pending Investigation J 3/02 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 00 30. Name and eddress of parson who complated causa of death (Item 23a) (Type, Print) 22 Brest Grotch Greca 5 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State APR 27 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14986 Amend #7,4/28/2000, BMW, Montg. Co Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Physician 24 2000 7:35PM Margaret Herz April /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Suburban Hospital Rockville Montgomery If Under 1 Year Months Deys If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Feb. 20, 19 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2⊠F 86 Yrs. 1914 North Dakota Director 137-30-7812 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pegas 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or Nems 23a or 28a-f show eny linity or other treumstic event, the Medical Examinal must be notified at Bottes. 1☑ Yes 2☐ No Directo Frederick Maryland Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 636 Lee Place 21702-4118 United States Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Yeer or Detes: 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - Americen Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peter Boa Jeannette Deason 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5417 Emerald Dr. Sykesville, MD 21784 Jonathan Herz (Son) 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crametory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4-26-00 Beltsville, MD Chesapeake Crematory 22. Name and Address of FecilityRapp Funeral & Cremation Services Stephen D. Lohrmann PA 21. Signature of Funeral/Service Licensed 140 933 Gist Aveune Silver Spring, 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final disaese or condition resulting in deeth) INTRA CRANIAL HEMORRHAGE 24hrs Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physicien and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury Due to (or es e consequence of): P.O. Box 68760, that initieted events resulting in death) Last Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records.

by been significant Completed cate has Hospital or Attending Physician: 24 hours after deeth. Funerel Director: After this cartificately filled in by the funeral director; g Be Certification: To

certificate

Division of Vital

24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? complation of cause of deeth? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

27. Menner of Deeth 1 Neturel 2 Accident

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stelled. 29c. License number 29d. Date signed (Month, Dey, Year)

29b. Signeture end title of certifier

D37891

April 25, 2000

20852

30. Nema and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print)

MD 121 Congessional Lane #409 Rockville Arajvanshi

31. Date filed (Month, Dey, Year)

APR 28 2000

32. Registrar's Signeture

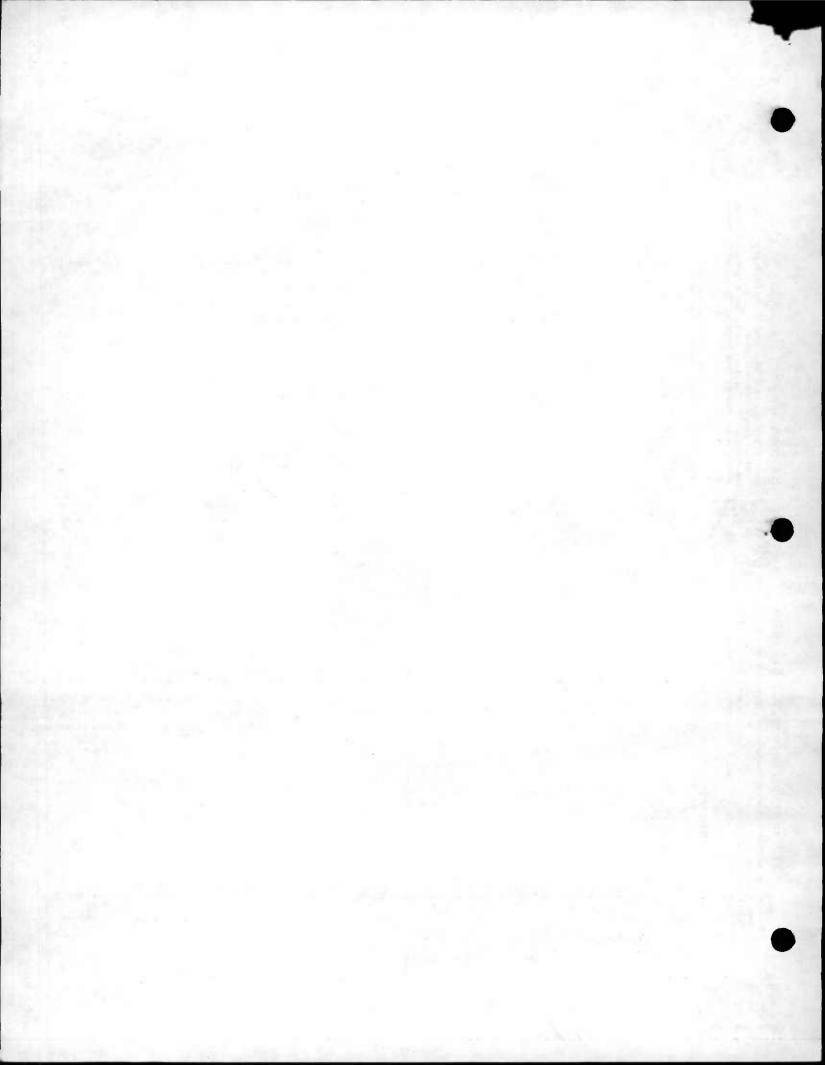
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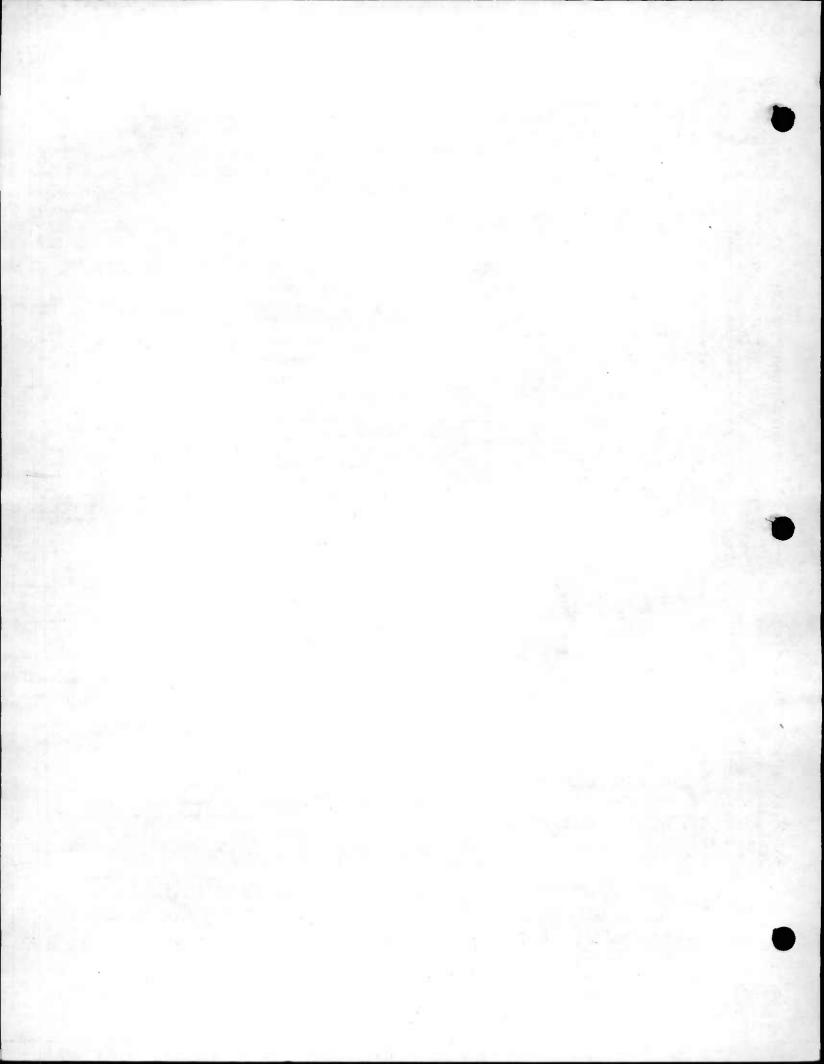


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Exami	ner	1000 Harrison Dri					Laure		Cation of Deet	4c. County		rge's
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Maryle -f ahov	Maryler Habow fired at	10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George's Laurel										10d. Inside City Limits  XXYes 2 □ No
7.28s	Je C	10e. Street end Number			10f.	Zip Code	1125			10g. Citizen of	What Cour	ntry?
h wid	al D	1000 Harrison Drive 20707								U.S.A.		
illed within 72 hours effer deeth with the Marylend Hygiene. ther than "natural", or items 23a or 28s-f show out, the Medical Eserties must be notified at	y Funeral Director	11. Maritel Stetus 1 Never Merried Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1 U,S. 1		cedent of lipecify Cub		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - Amenic ck, White,	etc.
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fe, Mic 1 end 2: Haaith ei em 27 le other trau		Elizabeth A. Horn	ung / Wife	100	0 Har	riso	n Driv	е	Laurel	Maryla	and 2	0707
四一三五百号.	ô.	20a. Method of Disposition  1 Burial 2 Cremetion 3 D		. Plece of Discemetery, of			ece)		Date	20c. Location	- City or To	own, Stete
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Deficility or price.		21. Signeture of Funeral Service Licens	0 0	0	22. Name	and Addr	ess of Fecilit	v		L Servic	_	
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To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a. Certifier  (Check only one)  1\infty Certifying Phy 2 Medical Exami	sician: To the best of my k ner: On the basis of exami	nowledge, de ination end/or	eth occurr rinvestigeti	ed et the ti ion, in my	ime, date en opinion, dea	d place, o	end due to the ed et the time,	cause(s) end m date end place,	enner es s , end due t	steted. o the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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eral	5. Social Security		Sex	7. Age (In yrs.	last birthday,	If Under 1		if Under		8. Dete of Bi	rth Vaarl	9. Birth	plece (State or For	eign
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edicai Certification:	- C Homicide		Duildi	ng, etc. (Specif	y/					July Dr 10	Siele/			
S	29e. Certifier	Certifying P	hysician: To the	best of my kee	wledge death	n occurred et	the time	e date as	d place	and due to the	CHUSA(s)	nd manner en	stated	
IC.	(Check only one)	2 Medical Exa	miner: On the ba	asis of examine	tion end/or in	vestigation, in	my op	inion, dee	th occurr	ed et the time,	date end p	pleca, end due	to the cause(s)	
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2	29b. Signeture en	d title of certifier	221	1 11	c no	29c. L	icense	number			29d. Date	signed (Month	, Day, Year)	
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tate	31. Dete filed Mo	nth, Day, Year)	2000 32. R	eg strer's Sign	eture	/	1							
gistrar		MIK Z 4	2000	Proposition of		. 11	200	41						

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4989 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Dey **Physician** April 24, 2000 6:45AM John Lockwood Hayes, Jr. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner VA Maryland Health Care System Perry Point If Under 1 Year 9. Birthplace (State or Foreign Country) Naryland 8. Date of Birth (Month, Day, Year 09/10/1926 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Yrs 73 Director 216-12-6541 Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Merylai Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Item 23a or 28a-4 show any Injury or other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 □ No Director MD Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? USA Apt 604 21078 Funeral 505 Congress Avenue 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 XYes 2 No Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White þ Yaar or Dates: 1944-46 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Safety Tower Operator 11th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Helen Lieske John Lockwood Haves, Sr. 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John F. Hayes- Son 4435 Tolchester Ct., Belcamp, MD 21017 Baitimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Harford Mem. Gardens 4/27/00 Aberdeen, MD 21. Signatura of Funaral Service Licenses 22. Name and Address of Fecility Mitchell-Smith Funeral Home, P.A. MD 21078 123 S. Washington, Havre de Grace, 23a. Part.). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Lung Cancer Examiner Due to (or as e consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of) P.O. Box Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease, Laryngeal Records, à 24b. Were autopsy findings eveilebie prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen Cancer, Colon Cancer, Cerebrovascular Accident pege 2 s 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1XX Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigetion 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier Clan (1chy D16608 April 24, 2000 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 10 VA Maryland Health Care System, Perry Point, Maryland 21902 Kam Ken Leung, M.D., APR 25 31. Dete filed (Month 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

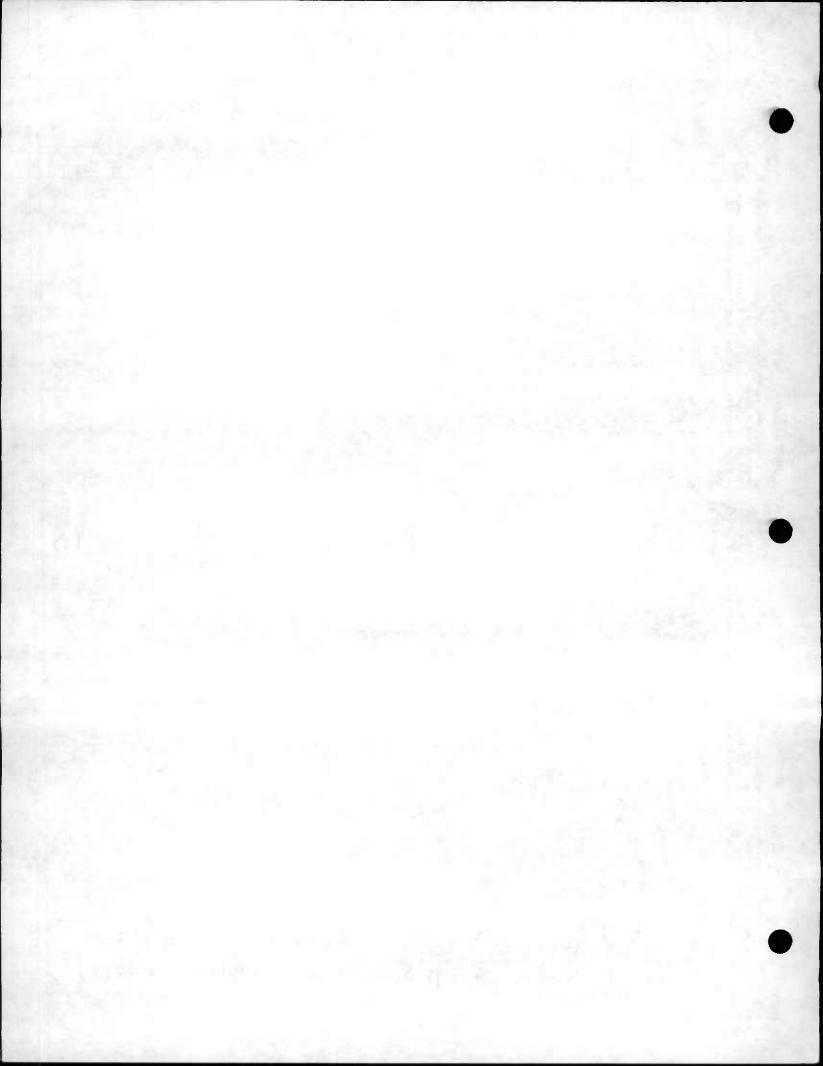
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NAME KNOWN TO PHYSICIAN: HAYES, JOHN

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sician	Decedent's Name (First, Middentification)	fla I ast)		Cert	ificate of	Death	2. Dete of De	Reg. No.		3. Time of Deat	
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edical miner	4a Facility Name (If not institution					4b. City, Town, or	April Location of Deet			23:10	
mmer	Anne Arundel N	Medical Ce	nter		I I	Annapolis		Anne	Arund	le1	
ral	5. Social Security Number	6. Sex	7. Age (In yrs. les	t birthdey)	tf Under 1 Year Months Devs		8. Date of Bi			lace (State or Foreitry)	
tor	048-12-4481	1□ M 2√ F	78	Yrs.			Novembe:	r 28, 19	21 Cc	nnecticu	
	Usual Residence of Decedent  10a. Stata 10b. County			1	0d. Inside City Lin						
natural, or hame 23e or 28e-1 show ideal Examiner must be notified at leted by Funeral Director	Maryland Queen Anne's Chester										
	10e. Street and Number		10g. Citizen of	Whet Coun	itry?						
	1510 Postal Road 21619							USA			
	11. Meritel Status	13. W	es Decedent of I Yes, specify Cub	lispenic Origin? (S en, Mexican, Puer	Specify Yas or No to Rican, etc.)		ca - Americ ck, White,				
by F	1 Never Merried 2 Mar 3 CN Widowed 4 Divorce	If Yes. G		_ 11	□ Yes XX No	Specify:		Specif	. Whi	.te	
8		nt's Education		16a. Decede	nt's Usuel Occup	pation		16b. Kind of B	usiness/înc	Justry	
Completed	(Specify only highest grade completed)  [Give kind of work done during most of work life. DO NOT use retired)  [He. DO NOT use retired]							Self-em	plove	d	
S	Newspaper Delivery							newspap			
Be	Andrews C. T							, Maiden Sumer	na)		
2	OCICIO										
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, 2										
mode. To Be Compl	Robert Hamilton/ Son 1510 Postal Rd. Chester, MD 21619  20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or										
	1 Burial 2 Scremetion 3 Removal from State 4 Donetion 5 Other (Specify)  April 19, 2000 Cheste										
4	21. Signature of Fuperal Septice		Ones		Nama and Addre		1 19, 20	ou che	ster,	MD	
Duc	Fellows, Helfenbein & Newnam Funeral										
rsician	23a. Pert 1. Enter the disease, or complications that cauchd the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or man line.										
	shock, or heert failure. Lis	t only one cause on	and line.						i	Onset end Death	
al er	Immediate Cause (Finet disease or condition resulting in deeth) e.									10	
	resulting in deeth)  Due to (or es e consequence of):										
Examiner	b										
xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury c.										
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Physician/Medical	resulting in death) Last  Pert tt. Other significant conditi			ng in the und		ven in Pert I.		tobacco use co		o the causa of de bably 4 □ Unki	
by Physician/Medical	resulting in death) Last  Pert tt. Other significant conditi	d		ng in the und		ven in Pert I.	115	<b>1708</b> 2□ No	3 Pro	bably 4□Unki	
by Physician/Medical	resulting in death) Last  Pert tt. Other significant conditi			ng in the und		ven in Pert I.	15 24a. Wes		3 ☐ Pro	bably 4 Unki	
by Physician/Medical	resulting in death) Last  Pert tt. Other significant conditi			ng in the und		ven in Pert 1.	24a. Wes	2 No s en eutopsy ormed?	3 Prof	ara eutopsy tindin eileble prior to mpletion of cause deeth?	
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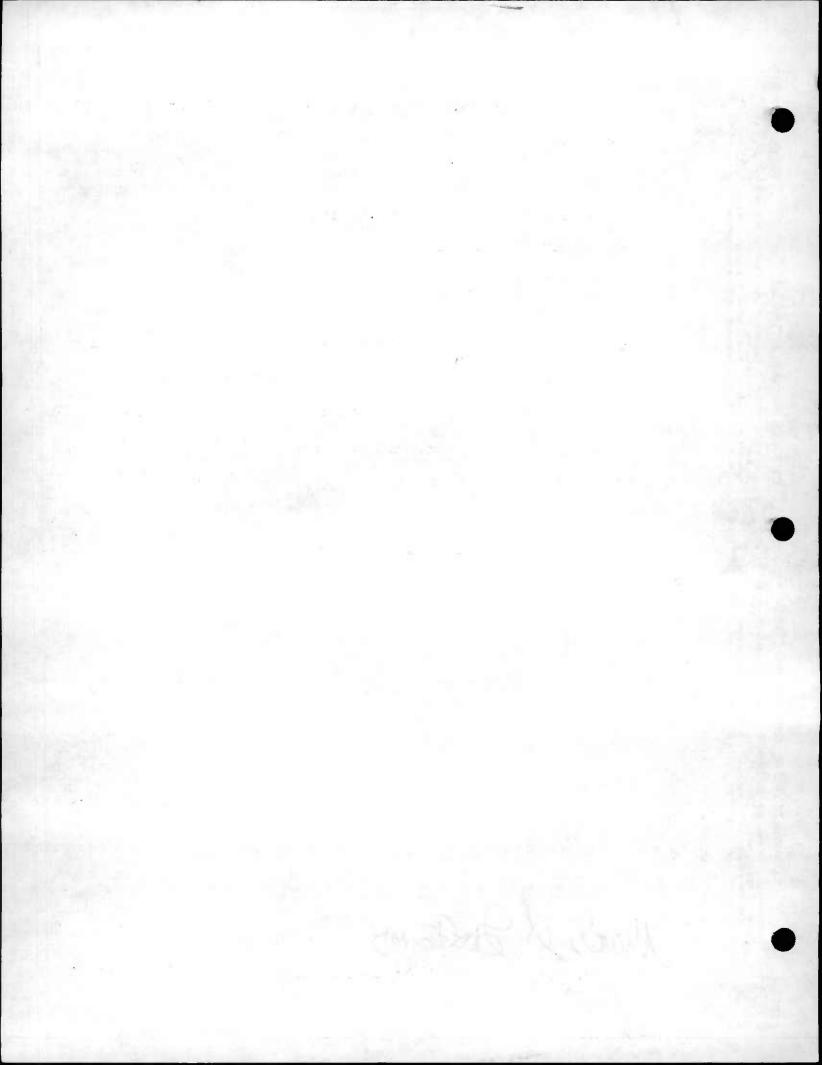


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4991 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** LEONARD APRIL D. JACKSON, SR 18,2000 11:20 AM /Medical 4a Facility Neme (If not institution, give streat end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner House | Rockville MONTGOMERY 6001 Muncaster Mill Rd./Casey 8. Date of Birth (Month, Dey, Year)
Aug. 23,1932 If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours M 2□ F Yrs. 218-24-6224 67 Director Wash. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mentel Hygiene. Important: if tem 27 is marked other than "natural; or items 23s or 28a-f show anonauti it hem 27 is marked other than "hatural; or items 25s or 28a-f show anonauti it has Medical Every or must be notified at these. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No Director MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10721 Shaftsbury Street 20895 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1951-53 1 Nevar Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carter Barron Elementery/Secondary (0-12) College (1-4or 5+) 12th Sight Manager Amphitheater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Robinson Ellis Jackson 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara D. Jackson (Wife) 10721 Shaftsbury St., Kensington, MD 20895 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Mem. Park 4/26/00 Rockville, MD 21. Signature of Funeral Service Licensee Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. usein ROCKVILLE, MD 20850 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical 9 months Metastatic Lung Cancer Examiner Due to (or es e consequence of): Physician/Medical Examiner use es the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury and Due to (or as a consequenca of): P.O. Box 68760, attending physicien for use es the buria thet initiated avents resulting in death) Last Due to (or es e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detac Yes 2 No 3 Probably 4 Unknown Records, 2 24b. Were eutopsy findings available prior to Be Completed 24a. Was en eutopsy completion of cause of death? Afterithis certificate has Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Wother (Specify HOSPICE 2 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation (X) Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of de 29c. License number 29d. Date signed (Month, Day, Year) 8 D0037620 Apr. 22, 2000 n who completed cause of death (Item 23a) (Type, Pr Mark S. Godec, 6001 Muncaster Mill Rd., Rockville, MD 20855 M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Deperson Registrar 2000 APR 25



					Cer	tificate o	or Death		Reg. No.		
Physician	1. Decedent's Nama (Fir	rst, Middle, Las	it)					2. Dete of D	eath Day	Year 3.	Time of Death
Medical	Sophie	(a	ka Jay)	Ja	ije			APRIL			45PM
caminer	4e Fecility Neme (If not	institution, give	street end number	)			4b. City, Town,	or Location of Dea	th 4c. County	of Death	
	St. Mary	s Hosp	ital				Leonard	ltown	St Ma	irvs	
eral	5. Social Security Number			ge (In yrs.	last birthday)	If Under 1 Y	ear If Under 24 I	fin. 8. Date of B			(Stete or Foreign
tor	164-03-081	15	□ M 2CXF	9	2 Yrs.	WOTHING DE	ays Tiours II	Sept.	9, 1907		PA
	Usual Residence of Deci			1							
	10a. Stete 10b	. County		10c. City	y, Town or Loc	ation					nside City Limits
ę		hiladel	phia	I	hilade	lphia					∰ Yes 2 No
Funeral Director	10e. Street and Number					10f. Zip Co	de		10g. Citizen of V	Mhet Country?	
<u>a</u>	3252 Cedar	St.				1913	4		USA		
ner	11. Maritat Status		12. Was Decedent Armed Forces	Ever in U,	S. 13. V	les Decedent	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or N	lo- 14. Rac	a - American Inc	dien,
	1 Never Merried	2 Married	1 ☐ Yes 2 🔀	No				deno racan, etc.)		ck, White, etc.	
þ	3 ⊠ Widowed 4 □ i	Divorced	If Yes, Give Year or Detes:		'	☐ Yas 2☑	No Specify:		Specify	White	
Be Completed	15. [	Decedent's Ed	ucation		16a. Deced	ent's Usuet O	ccupation	Edina.	16b. Kind of B	usiness/Industry	
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E	7	(0-12)	College (1-40)	34)	Н	omemak	er		Own	Home	
9	17. Father's Neme (First,	Middla, Last)					18. Mother's	Name (First, Midd	e, Maiden Suman	10)	
To B	Adalbert	Waz					Не1е	n Majews	l-i		
-	19e. Informent's Name/F	Relationship (7	vpe, Print)		19b. Meilin	Address (St	reet end Number or			Stete, Zip Code	a)
	Thaddeus		Son		4793	3 Wate	rview Dr.	St Ini	goog MD	20697	
	20e. Method of Disposition		3011	20b. P	lece of Disposemetery, crem	ition (Name o	IVIEW DI.	Date		City or Town, S	
)	1 Buriet 2 □ Cre							- 14 100			
	4 Donetion 5			St.	Peter		2	5/1/00		elphia,	
	21. Signature of Funaral	Service Lican	see				ddress of Fecility				rvice
8	Other	151	1	QQ.	20 5	51/ Vi	ne St. Al	exandria	, Va 223	10	
	23a. Pert1. Enter the dis shock, or heart feit	seese, or comp	olications thet cause	d the deeth	n. Do not ente	r the mode of	dying, such es care	diac or respiratory	errest,	Арр	roximete rval Between
in i	Shock, or heart reiti	ure. List only o	one cause on eech t	ine.						Ons	et end Death
i	Immediate Cause (Final			-	log	Dee	Amo.	anti	eretoi	1/0	-gr
r	disaasa or condition resulting in death)			200	0		1	1	-	. 1 6	2
6			//	000000	As a consequ	rei i di di	1	nli	J H	47 /	1
n/Medical Examiner			b	200	11/1			-			7
xai	Sequentially list condition if any, teading to immedicause. Enter Underlying Ceuse (Disease or injury that initiated events	ns, iete	1	Jue to to	was counted	ence or):	1.17	-1	10/4	10	2
T T	Ceuse (Diseese or injury	1	. /	8	000		and the same	7		0	1/2
o p	resulting in death) Last			Bue to (or	as a consequ	ence of):					
n/Medical Examir		-	d								
Sic	Pert II. Other signiffcant	conditions co	entributing to death b	out not resu	ulting In the un	derlying cause	a giyan In Part L	23b. Di	d tobacco use co	ntribute to the	cause of death
should be obtached for ieted by Physicia	/	Inc	xic d	ene	cep	200	-	1[	Yes 2□ No	3 Probably	40 Unknow
by	11	,			/	0					
2									s en autopsy formed?	24b. Were et	utopsy findings a prior to
Siet								_	/		tion of cause
Completed by Physicia								11	IVan CON		
Ö	OS Was	medical .		/					Yes 2 No	1 Li Yes	2 □ No
о Ве Сотрі	25. Wes casa rafarred to examiner?	-	Hospitet:				Other	Deeth (Check only			
-	1 Yes 2 Mo		1 La Inpati		ER/Outpatient			g Home 5□Re			
by ma lunaral	27. Manner of Deeth 1 Deaturat 5 [	Pending	28a. Dete of Inju (Month, Da	ay Year)	28b. Time of Injury		Injury et Work?	28d. Describe	how injury occur	red	
att	2 Accident	Investigation				М	1 Yes 2 No				
tific	3 Suicida 6 L 4 Homicide	Could not be determined	28e. Pleca of In building, e	jury - At ho	ma, farm, stre	et, factory, of	lice		(Street and Numb own, Stete)	per or Rurel Rou	ite Number,
Certification:			Duriding, 6	(upoul)	,			0.07 07 1	,,		
18	29a. Certifier 1	Certifying Phy	rsician: To the best	of my know	wledge, deeth	occurred et th	e time, date end pl	ace, end due to th	e cause(s) end me	enner es stated	.1
edical	(Check only 2 1 one)	Medical Exam	iner: On the basis of end menner st	of axaminet	ion and/or inv	estigation, in r	ny opinion, death o	ccurred et the time	, date end ptece,	and due to the	cause(s)
Me	29b. Signature and title of	of certifier				29c. Lic	cease aumber		29d. Date signe	d (Month, Day.	Year)
omplately filled in by the					-			-			

State Registrar

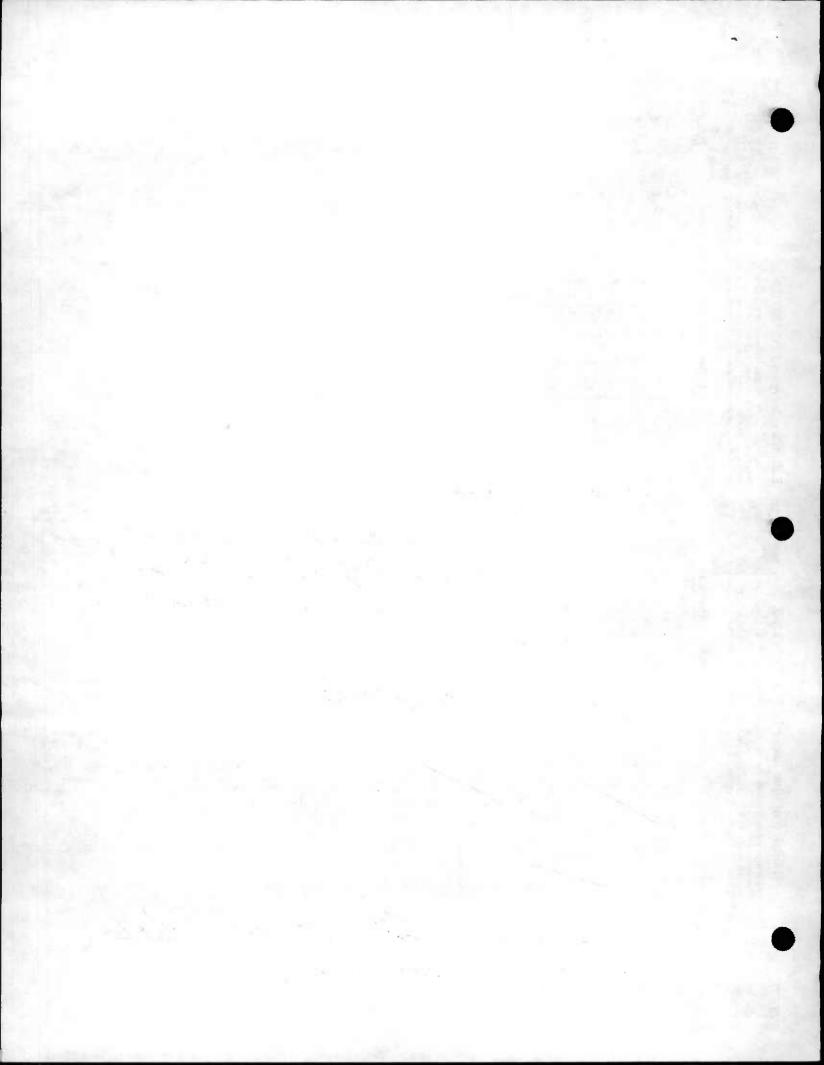
SOPHIE JAJE

HOLLYWOOD, MD 20636

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

DR. DAVID M. FEDERLE

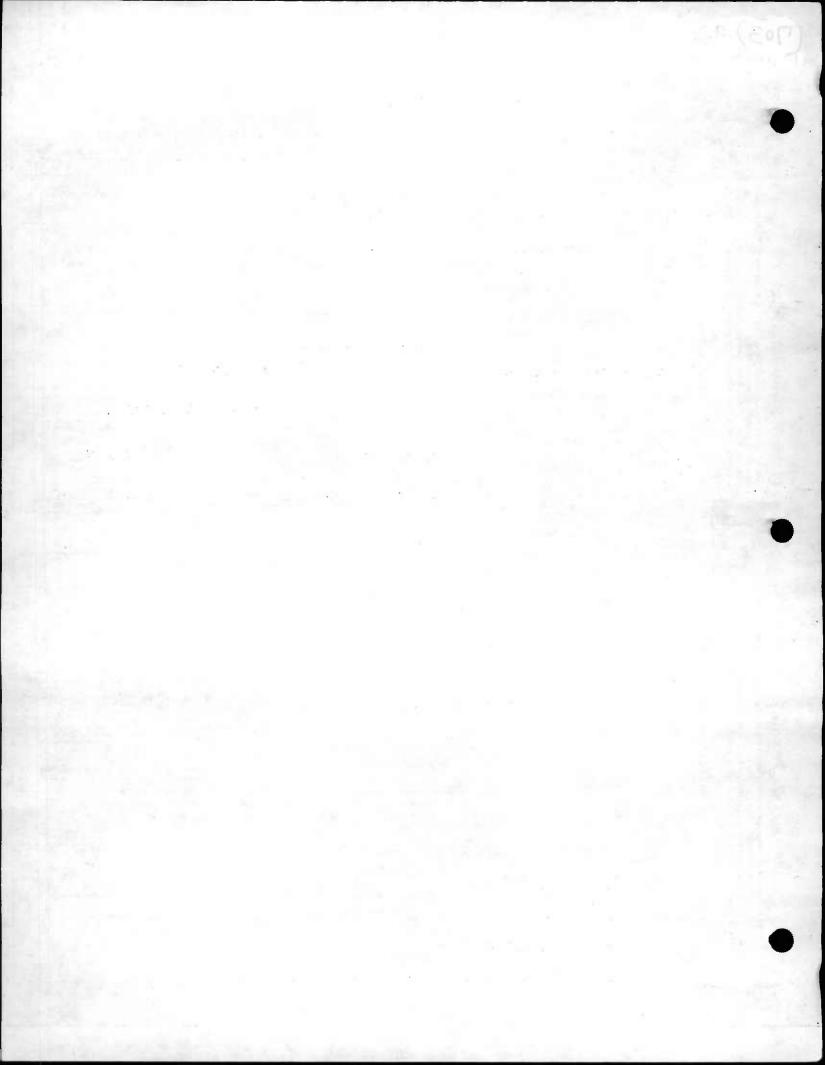
31. Deta filed (Month, Day, Year) APR 2 8 2000



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				-	Certificate of		R	eg. No.	U	14993
	Physician	Decedent's Name (First, Middle, L.		7.1			April 2	n Daynoo	Year	3. Time of Death
	/Medical	Agnes	Dorothy	Joni	nstone			_		7:35PM
	Examiner	4a Facility Name (If not institution, g				4b. City, Town, or Lo Silver Sp		4c. County		,
		Holy Cross		W	thday) If Under 1 Year	If Under 24 Hrs.	_			
	Funeral Director		4DM 6DE	(In yrs. last bir	Yrs. Months Days	Hours Min.	(Month, Dey August	14°,191	9. Birthpl Goun	lace (State or Foreign try) Cago, Illino
	N 11	10a. State 10b. County		10c. City, Tow	n or Location				10	0d. Inside City Limits
	To The Po	Virginia Arlingt	on	Arl	ington					1 ☐ Yes 2 ☑ No
	1284 I	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Coun	try?
	1215-0020  within 72 hours after death with the Maryland and that "natural", or items 23a or 28-4 show he Madical Evantible must be notified at amplieted by Funeral Director	4909 North 13th	Street		22207			United	State	28
21215-0020		11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		13. Was Decedent of H If Yes, specify Cubi 1 Yes 2 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
5-0	ted att	15. Decedent's E	ducation	16a.	Decedent's Usual Occup (Give kind of work done	pation	ina	16b. Kind of Bu	usiness/Ind	lustry
21	or than "neturity to your than "neturity to the wedge of the Completed	(Specify only highest gi	College (1-4or 54	+)	life. DO NOT use retire			FHA		
cA 2	Contraction Co	12		F.	ield Represe					
/land	Maryiand and 2 should be fill the and Mentel H 27 is marked oth r treumatic even To Be	17. Fether's Name (First, Middle, Las Charles Pelis	ohnstone			18. Mother's Name Bessie I		Maiden Sumen	ne)	
Man		19a. Informant's Name/Reletionship  Dennis Jacques	(Type, Print) Co Executo		. Meiling Address (Street 69 Lakeside					
ē .		20a. Method of Disposition		20b. Place of	Disposition (Name of			20c. Location -		
Baitimore,	t: M i	1 Burial 2 Cremetion 3 4 Donation 5 Other (Spec			ry, cremetory or other ple	4/	27/2000	01 41	0.0	
	Department of important: If eny injury or poce.	21. Signature of Funeral Service Lice		Crema	tion Center	ass of Facility				VA
B		181	0000	000	Robert G.	Murphy Ful				
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that examine	he deuth. Do r	4510 Wilso	n Blvd. A	<u>rlingtor</u> or respiretory em	, VA 2.	2203	Approximate
7 p	hysician	shock, or heart laiture. List ont		1	Intervel Between Onset and Death					
100	Physician / /Medical	Immediate Cause (Final disease or condition	Cano	dianulm	onary Arrest	<i>†</i>			į	2 days
E	Examiner	resulting in death)	8		consequence of):				1	z days
-	9				Failure				i	3 days
	g physician and as the burlatransit	Sequentially list conditions,	D	Due to (or es e	consequence of):				1	
Ö,	er de la Composition de la Com	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sepa	ticemia						1 week
68760,	the the	that initiated events resulting in death) Last	0.	ue to (or es a c	consequence of):					
9 ×	to the attending physicial but the attending physicial letteched for use as the but Physician/Medical		d. Pneu	ımonia					1	
Вох	the attendin hed for use									
P.O.	yal	Part II. Other significant conditions	contributing to death but				the cause of death?			
0	deta de		Congestive	Heart 1	Failure		1 Y	98 2∐ No	3 Prot	pably 4 Unknown
Records, P.O. Box 68760,	the less been signed by the attending page 2 should be detached for use.  Completed by Physician/N		Seizure Dis	order		- 1	24a. Wes e	n eutopsy med?	eva	ore eutopsy findings ailable prior to mpletion of cause deeth?
I Rec	5 0 C				5			c b/1		
8	C Par	25 Was seen referred to medical	1				1 U Y		t L	Yes 2 No
of Vital	cartification in Be	25. Wes case referred to medical examiner?	Hospital:	• • □ ED40	Ott	26. Place of Deet				
0	rthis or rthis or rail dire	27. Manner of Death	28a. Date of Injury (Month, Day		ripatient 3 DOA Circles of Carlo Working	4 LI Nursing Ho	me 5 Reside			0
00	to the standard	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) I		rk? ]Yes 2 □ No				
Division	octor sy the	3 Suicide 6 Could not	28e. Piece of Injur	ry - At home, la	rm, street, factory, office		28f. Location (S	treet and Numb	ber or Rure	I Route Number,
in s	a blector. After the by the funer Certification:	4 Homicide	building, etc.	(Specify)			City or Town	n, Stete)		
1	within 24 hours after death.  To the Funeral Director: After this cardificate he completely filled in by the funeral director, page  Medical Certification: To Be Com	29a. Certifier 1 (X Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner stet	examination an	, death occurred et the tind/or investigation, in my o	me, date and place, opinion, death occurr	end due to the c ed at the time, d	ause(s) end me ate and place,	enner as st and due to	ated. the cause(s)
4	M ompl	29b. Signature and till of portifier	1 0	1	29c. Licens	se number	2	9d. Date signe	d (Month,	Day, Year)
	15	1/1/4	V.	. (	D52	261		04-21	-00	
		30. Name and address of person who	completed cause of the	dith (liters 23a)	W			V7 41		
		Alan R. Segal 12				a. MD 209	02			
	State	31. Date filed (Month, Day, Year)	32. Registra		more spring	y, 1110 6091	V.E.			
	Registrar	APR 242	2000 Jene	va ,	9. Spork	2				

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Yeer 24, MYRTLE Κ. APRIL 0840 AM 2000 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 14643 Bauer Drive, #312 Rockville MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 14,1912 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) Months Deys Yrs 87 Maryland 153-20-0469 Usuel Residence of Decedent 10d. Inside City Limits 10e. Stete 10c. City. Town or Location 1 ☐ Yes 2 ☑ No MD Montgomery Rockville 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 14643 Bauer Drive, #312 20853 U.S.A. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S Armed Forces? 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black XIXWidowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 7th Domestic Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Selena Thomas Frank King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Frank King (Brother) 6108 Dry Leaf Path, Columbia, MD 21044 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Metropolitan F/Serv. 4/25/00 Alexandria, VA 22. Neme end Address of Facility 21-Signature of Funeral Service L SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 mplicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. 23a. Part1. Enter the disease shock, or heart failers. Approximete Intervel Between Onset end Death cardiovascular disease Immediate Cause (Final diseese or condition resulting in deeth) rears Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 NO 1 Yes 1 Tyes 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

Show

Director

Funeral

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Completed

Be

2

item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be inclined at

with the Maryland

death

permit. Peges 1 and 2 should be filed within 72 hours after Department of Haalth and Mantel Hygiena. Important: If Itam 27 is marked other than "natural any injury or other fearments."

/Medical

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physician end s the burial-transit signed by the a cate has been sig certificate has director, After this funerai

Examiner Physician/Medical þ Completed Be To Certification:

The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: s after death. within 24 hours after dea To the Funeral Director completaly filled in by th

To the

State Registrar

edical

(Check only one)

31. Dete filed (Month, Dey, Year)

25. Was case referred to medical exeminer? Hospital: 1 Inpatient Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury ef Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Natural 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

39 Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Patricia

10m

32. Registrer's Signature

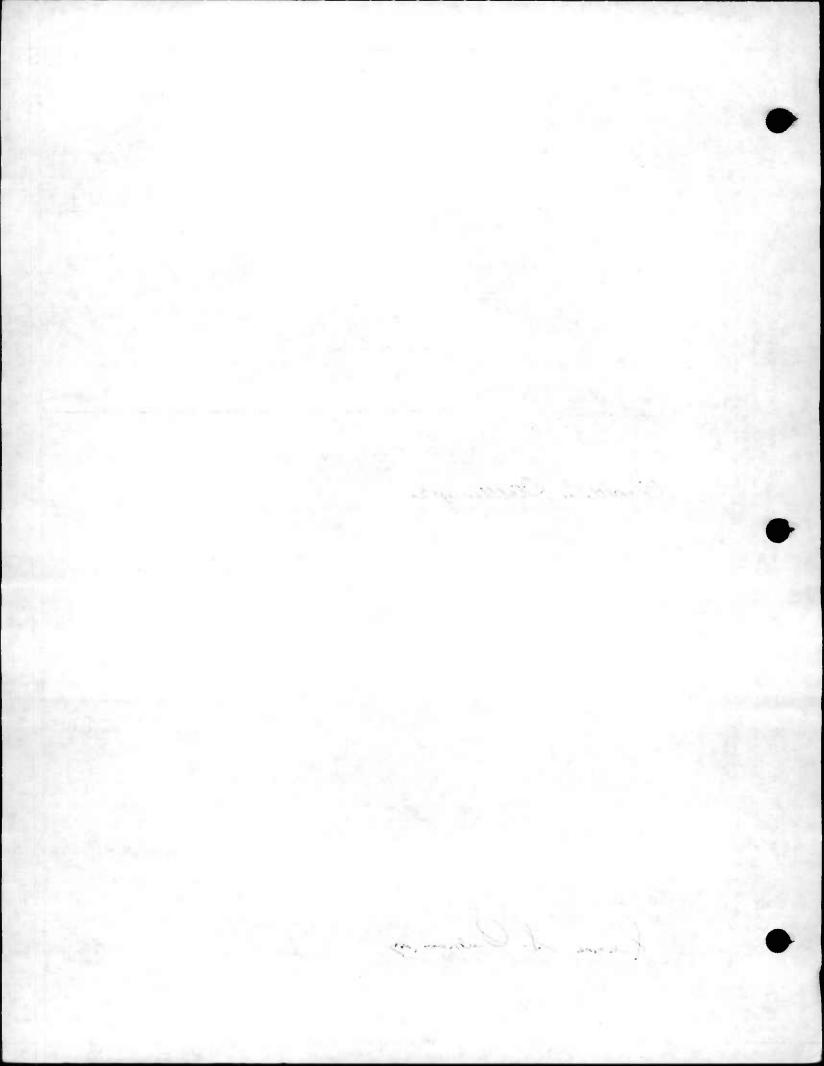
Pike, PMB 348, Rockville, MD 20852

APR 25 2000

State of Maryland / Department of Health and Mental Hygiene

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AMENDED ITEM	S #5,10a-10f,16a,19b PF 1. Decedent's Nama (First, Middla, Las		9/11/00	Mertificate	of Death	2. Data of De			Fima of Death	
Physician	EDWARD KATZ					APRIL :	21, Day 2000	Yaar ]	:42 P.M	
/Medical Examiner	4a Facility Nama (If not institution, give	street and number)				Location of Death	4c. County	of Death		
	8711 BELLWOOD RC				BETHESDA		MONTGO	MERY		
Funeral Director	374 12 1317	7. Aga (In	yrs. last birth	Months	Yaar If Undar 24 Hrs Days Hours Min		h y, Year) 1923	9. Birthplace Country) MICHIG	(Steta or Foreign AN	
n the Maryland r 28e-f show notified at rector	Usual Residence of Decedent  10a. State FL 10b. County MON MONTGOME	INTERNATIONAL PROPERTY.	c. City, Town	IV K	EY LARGO				nsida City Limits	
office death with the Mark farms 23s or 28s-1s increased a profiles. Funeral Director	10a. Street and Number 8711 BELLWOOD ROAD 100 ANCHOR DRIVE #37	F. 11		10f. Zip C	oda <del>0817</del> 3303		10g. Citizan of Whet Country?  U. S. A.			
020 urs	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Evan Armed Forcas? 1 XYas 2 No If Yes, Give WW ~ Yaar or Datas.			nt of Hispanlc Origin? ( Cuben, Maxican, Pue No Specify:	Specify Yas or No rto Rican, etc.)	14. Race Black Specify:	- Amarican In k, Whita, atc. WHITE		
1 21215-0020 led within 72 hours et bygiene. For than "natural", or it, fre Medical Execution Completed by F	15. Decedent's Ed (Specify only highast grad Elementery/Secondary (0-12)	(Giva kind of work done during most of work life DONOT use retired)  TRICK DEAL FR				orking	16b. Kind of Bu	sinass/Industry		
202	A7 5 ab 4 bb 4 5 a 45 a 4 a	4 YEARS	TRU	CK DRIVE	R/PRESIDEN'	Γ	TRUCK D		IIP	
Maryland 2 d 2 should be filed tith and Mental Hygi tith and Mental Hygi T7 is marked other traumatic event, if	17. Fether's Nama (First, Middla, Last) HYMAN KATZ	IDA GRU					Maidan Sumam	9)		
y, Mar and 2 sho neith and 127 is m	19a. Informant's Name/Ralationship (7 ANNABELLE KATZ, W	IFE	97	ANCHOR D	Straat and Number or F	Rurel Route Number				
Dearlimore, Mi permit. Pages 1 and 2 Department of Heelih a important: If flam 27 is any injury or other tra pince.	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Othar (Specify		Ob. Place of I cematary	Disposition (Nama crametory or other	of er plece) • GARDENS	Data 4/24/00	FALLS C	City or Town, 5		
Balt permit. Departri Importa any inju	21. Signatura of Funaral Sarvice Licen	Otates.			Addrass of Facility KY-GOLDBERG CKVILLE PI					
	23a. Pert1. Entar tha disease, or comp shock, or haart failura. List only of	lications that caused the	eath. Do no					App	roximate	
Physician	Shock, of haart failura. List only t	one cease on geon me.							vet Between at and Daath	
/Medical Examiner	Immediate Cause (Final disease or condition as will be a condition a							3 M	ONTHS	
je je	resulting in death)	nsequence of):				2 Y	EARS			
60, be executed cician and buriel-transit	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events  Dua to (or as a consequence of):									
X 68760, entificate be examined by see the buriel.  Medical Ex	that initiated events rasulting in death) Last	CDua	to (or as a co	nsequance of):	TITLE.		The last			
P.O. BOX nat the death cert d by the attendin setached for use.	Part II. Other significant conditions co		t rasulting in	ha undarlying ceu	se given in Part I.	23b. Dld	23b. Did tobacco use contribute to the cause of			
that the de ed by the ed deteched 'Physic					101			Yes 2 No 3 Probably 4 Unknow		
I Records, P.O. Box 68760,  The law requires that the death certificate be executed tale has been signed by the attending physician and page 2 should be detached for use as the buriel-transic pege 2 should be by Physician/Medical Exami							en autopsy mad?	availebl	utopsy findings a prior to tion of causa	
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g P G	27. Mannar of Death  ★☆Natural 5 Pending 2 Accident Investigation		ar) 28b. Ti	ma of 280 ury M	injury at Work? 1 ☐ Yas 2 ☐ No	28d. Dascribe	how injury occurr	ed		
DIVISION ( that or Attending P irs after death. The Director: After t iled in by the funers  Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)					ation (Straat and Number or Rural Routa Number, or Town, Stete)			
n 24 hound in 24 h	(Check only 2 Medical Exam	rsician: To the best of my iner: On the best of axe and manner stated.	knowledge, minetion and/	death occurred at or investigation, in	the time, date end pled my opinion, death occ	ce, end due to the curred et the tima,	ceuse(s) end ma date and place, a	nnar es steted and due to tha	cause(s)	
To the To the Common Common M	29b. Signatury and titla of certifier	S. Out	tan ,		D14111		29d. Data signed		Year)	
- 4	30. Neme and addrass of person who of JEROME S. PUTN	omplated cause of deeth	(Item 23a) (T	ype, Print)	AVENUE, CI	HEVY CHAS	SE, MARY	LAND 2	.0815	
State Registrar	31. Data filed (Month, Day, Year) APR 25 21	32. Registrar's		9. Spo	all l					



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death APRIL 19,2000 **Physician** ROBERT KENDALL 9:00 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) AUG. 2, 1921 Birthplaca (Stata or Foreign Country) MARYLAND 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 20 F Yrs. Director 215 18 0064 78 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. MD. CALVERT 1 Yes 2 □ No Director SUNDERLAND permit. Pages 1 and 2 should be filed within 72 hours after death with the Mi Department of Heelih and Mentel Hygiene. Important: If them 27 Is merked other than "natural", or fleme 23s or 28ss-1 a any injury or other traumatic event, the Medical Exeminer must be notified ORGs. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20689 UNITED STATES 2231 GREEN VALLEY DRIVE Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1⊠Yes 2□No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian 11. Marital Status Black, Whita, etc. 1 Never Married 2 M Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPET AND TILE INSTALLER 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Sumama) Be WADE KENDALL HATTIE POLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) SHIRLEY P. KENDALL, WIFE 2231 GREEN VALLEY DRIVE, SUNDERLAND, MD. 20689 20b. Place of Disposition (Nama of cemetery, crematory or other place PARKLAWN CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/22/00 ROCKVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME 21. Signature of Funeral Service Ligan P.O. BOX 5038, LAYTONSVILLE shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath Physician Immediata Cause (Final disease or condition resulting in death) /Medical VENTRICULAR FIBRILLATION 45 MIN. Examiner Due to (or as a consequence of): Physician/Medical Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burlai-tran Due to (or as a consequence of): CORONARY ARTERY DISEASE Due to (or as a consequence of) STROKE Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To

Attending Physician: The law requires that the death certificate be executed pue anding physicien a Box 68760. been signed by the a should be detached t P.O. Division of Vital Records, s certificate has b director. this funeral after deeth. To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th

Baitimore, Maryland 21215-0020

Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1∏ Yes 2∏No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

D 40804

29d. Data signed (Month, Day, Year)

APRIL 20,2000

3

Medical

29b. Signature and title of certifier

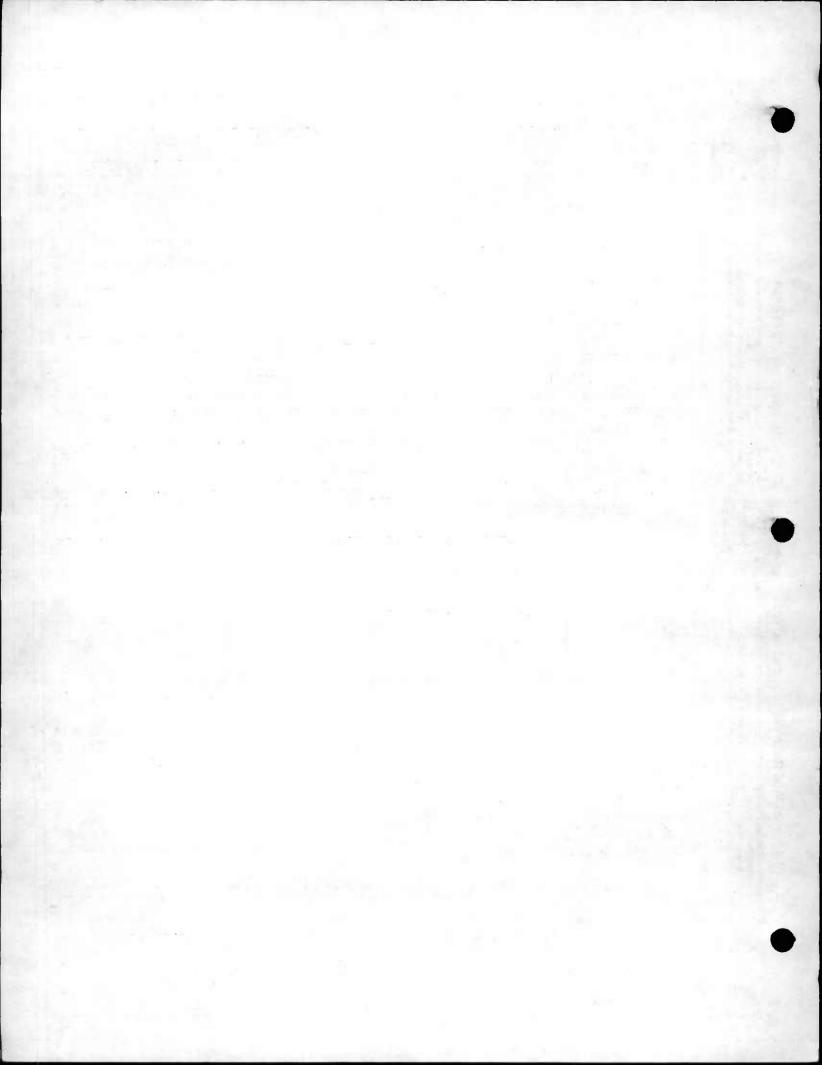
Thomalilian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KEWAL SHARMA, 10620 GEORGIA AVE., #114, SILVER SPRING, MD. 20902

State Registrar

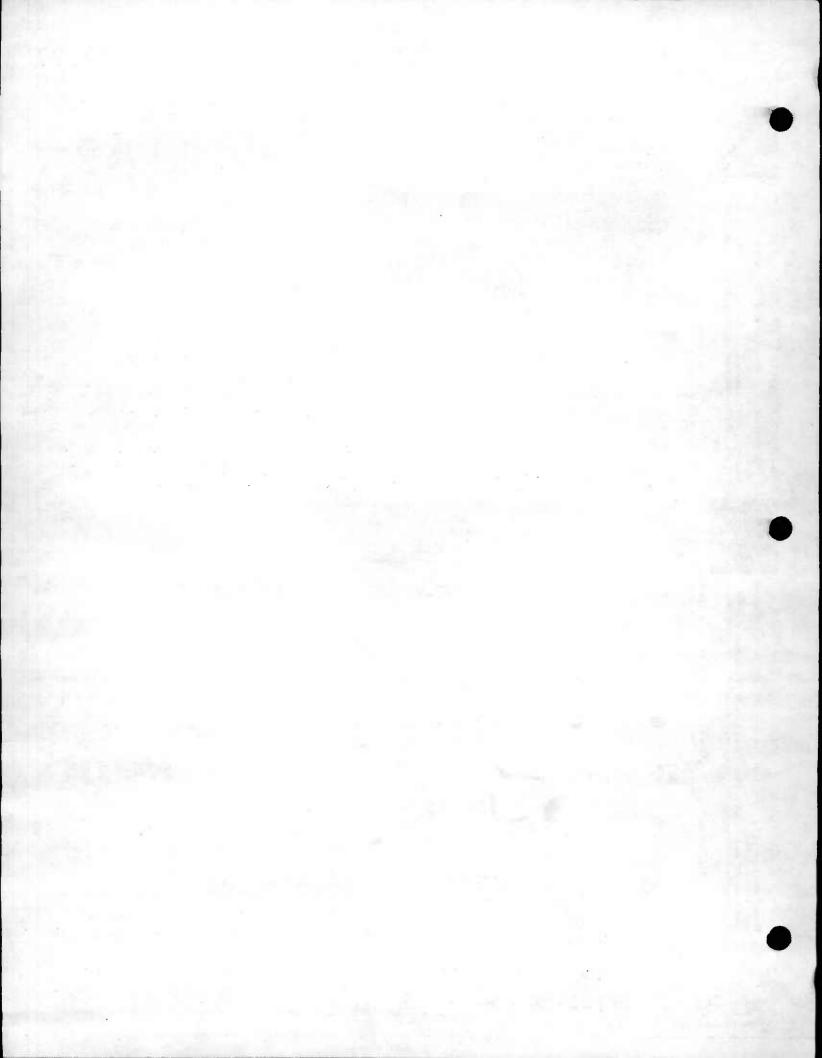
31. Data filed (Month, Day, Year) 32 Registrar's Signature APR 2 4 2000





State of Maryland / Department of Health and Mental Hygiene 4997 Certificate of Death 3. Time of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Death Month Day **Physician** Kwang R. April 20 2000 9:00 AM Kim /Medical 4b. City, Town, or Location of Deeth 4a Fecility Nama (If not institution, give street end number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery ff Under 1 Year If Under 24 Hrs. 8. Data of Birth (Months, Day, Year)

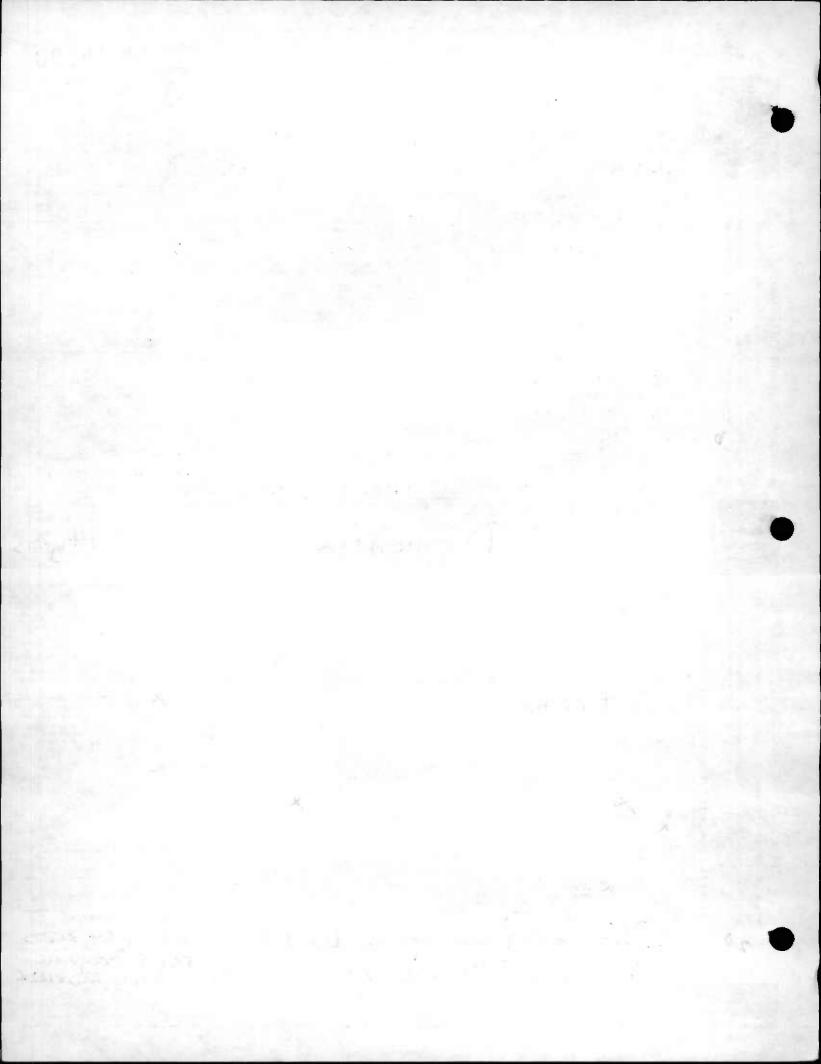
Deys Hours Min. Dec 2, 19/ 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 ★M 2 □ F Yrs. 1928 361-92-4609 Korea Director Usual Rasidance of Decedant Peges 1 and 2 should be filled within 72 hours efter death with the Meryland nant of Health end Mentel Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinar must be notified. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3421 Hampton Hollow Dr., #A 20904 Funeral Korea 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 ☐ Yas 2 ★No If Yas, Giva Year or Detas: 1 ☐ Navar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: ģ Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Engineer Electronics 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Sa Kook Kim Me Mul Park 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) permit. Peges 1 and 2 s
Department of Health er
Important: If Item 27 Is
any Injury or other trau 3421 Hampton Hollow Dr., #A, Silver Spring, MD 20904 Young S. Kim / Wife 20b. Place of Disposition (Neme of cematary, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata Fort Lincoln Crematory 04/22/00 Brentwood, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue MU Silver Spring, Maryland or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. 23a. Part1. Enter the diseasa Approximata Intarval Batween Onsat and Death **Physician** Immediate Ceuse (Finel disaasa or condition rasulting in death) /Medical Liver Cancer - end stage Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the deeth certificate be executed nding physician and use es the bunal-tran Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury Dua to (or as a consequence of): P.O. Box 68760. that initiated evants rasulting in death) Last Dua to (or as a consequence of). signed by the at d be detached for Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, Completed by 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Wes an autopsy page 2 s has 1 ☐ Yas 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa refarred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Pending t hours after death. uneral Director: Aft ely filled in by the fur 1 Yes 2 No 2 Accident investigation 6 Could not be datamined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) à 4 - Homicida To the Hospital of within 24 hours af To the Funeral Dicompletely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and plece, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signatura and title of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) 04/20/2000. D0053504 3 30. Name end addrass of person who complated causa of daeth (Itam 23a) (Type, Print) Shirin Trachiotis, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 32. Registrer's Signatura 31. Date filed (Month, Dey, Year) State APR 25 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 4998 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month **Physician** Mitsuko Kinoshita April 23, 2000 5:00 P.M. /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Morningside Nursing Home Prince George's Laurel If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug 10, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (Stete or Foreign **Funeral** 1 □ M 2 X F Months Days Yrs. 80 **Director** 548-24-4096 California Usuel Residenca of Decedent 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits ₩ Yes 2 No Director Maryland Montgomery Burtonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 2 rma 23a 4221 Cedar Tree Ln 20866 USA Funeral filed within 72 hours efter death Hema 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Detes: Wes Decedent of Hispanfc Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Meritel Stetus Black, White, etc. Never Merried 2 Married Baltimore, Maryland 21215-0020 6 Specify: Asian 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced natural Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglena. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen Important; if Item 27 is marked other the any Injury or other traumatic avant, the page. 12 Graphic Designs Artist 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Iku Okada Takejiro Kinoshita 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. fnforment's Neme/Reletionship (Type, Print) 4221 Cedar Tree Ln, Burtonsville, MD 20866 Sumie Kinoshita/Niece 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Apr 26 Fort Lincoln Crematory Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Hines-Rinaldi Funeral Home, Inc Donnell alla 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** fmmediete Ceuse (Finel diseese or condition resulting in death) /Medical ment ear **Examiner** Due to (or es e consequence of) Physician/Medical Examiner as the bunal-transit The law requires that the death certificete be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): Box 68760, Due to (or as e consequenca of) USB Po P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were eutopsy findings evailable prior to completion of cause of death? director, page 2 should Be Completed 24a. Was en eutopsy performed? certificate has 1 ☐ Yes 201 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attanding Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending Investigation 1 Neturel Injury within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 \ Homleide edicai Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es steted.

Medicaf Examíner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29a, Cartifier To the 29b. Signeture end title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 20 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5505 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State 27 APR 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene 4999 Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Physician 04 20 2000 19:45 pm Judith Corral Koch /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery If Under 1 Yeer | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Date of Birth (Month, Dey, 02 24 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplece (Stete or Foreign Country) **Funeral** Deys Months 1 M ZCXF Yrs 1952 578-62-7181 48 Washington, Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Depertment of Health and Mantal Hygiena. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any Injury or other traumatic avent, the Head call Exercises must be notified at once. 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Montgomery Silver Spring 10f Zip Code 10g. Citizen of What Country? 10e Street and Number 20905 15108 Timberlake Drive USA Funeral 14. Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Janet V. Vaughn 2 Albert R. Koch 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Alan J. Koch / Brother 6212 41st Place, Hyattsville, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4/25/00 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Peri1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** . RIGHT MIDDLE CEREBRAL ARTERY /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner HEMORKHAGE Due to (or as e consequenca of): Examiner b. COCAINE AND ALCOHOL ABUSE physician and s the burial-transit that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last · DEPRESSION Division of Vital Records, P.O. Box 68760, Physician/Medical ettending ph for use as t signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown þ 24b. Were eutopsy findings eveileble prior to been sign 24a. Wes en eutopsy performed? Completed completion of cause of deeth? certificate has b lirector, page 2 s 2 No 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred To the Hospital or Attanding Pi within 24 hours after daath. To the Funeral Director: After th completely filled in by the funera Certification: 1 Metural 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

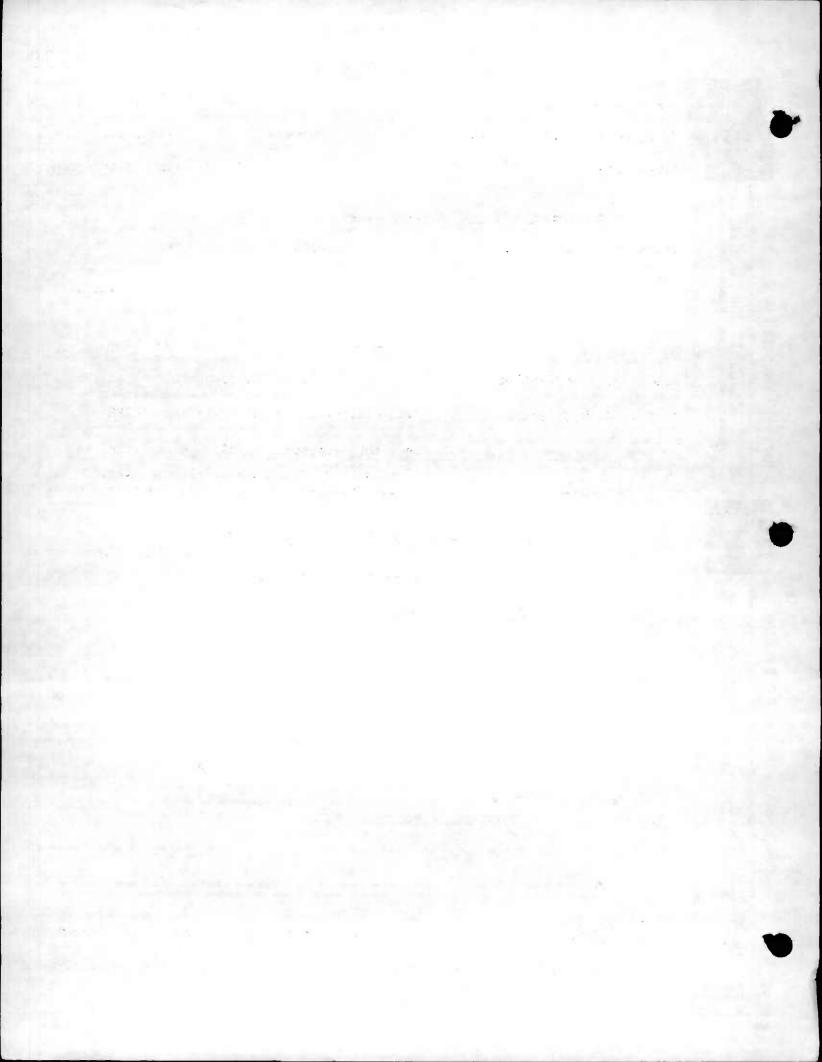
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner stated. edicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number FEdap My April 21, 2000 D-3798394 20 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) JOHNY EDAPPULLY. M.D; 3411 OLANDWOOD CT +106, OLNEY, MD. 20832 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

**DHMH 16 Rav 6/95** 

State

Registrar

APR 25 2000



State of Maryland / Department of Health and Mental Hygiene

5000 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Mildred Kolar April 20 2000 5:55 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1510 Gridley Lane Silver Spring Montgomery Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year)
June 19, 1910 5. Sociel Security Number Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2∑F Months Yrs. 89 Director 041 03 5194 Connecticut **Usuel Residence of Decedent** permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at DDGS. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1510 Gridley Lane 20902 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဤ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 Ĭ No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) 12 College (1-4or 5+) Line Worker Factory 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Stanley Bodetka Josephine Pabis 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1510 Gridley Lane, Silver Spring, MD Louis J. Kolar / Husband 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cremetion 3 ☐ Removel from State April Chesapeake Crematory Inc 21,2000 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22 Rampart de Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 2 21. Signature of Funeral Dohuman that caused the 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line. Approximate Interval Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Malignancy of Unknown Primary Site months Examiner Due to (or as a consequence of): an/Medical Examiner attanding physicien and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequenca of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown É been sig 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? ils certificata hes by director, pege 2 sh 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after deeth.
To the Funeral Director: After this certifica completaly filled in by the funeral director, t 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 28b. Time of 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner steled. edical 29b. Signeture and title of certific 29c. License number 29d. Date signed (Month, Dey, Year) 16 D29675 April 21, 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Ralph Boccia M.D. 9707 Medical Center Dr. #300, Rockville, MD 20852 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State **APR 25** 2000 Registrar Renew